DOCUMENT RESUME

ED 403 368 UD 031 482

AUTHOR	Rocha-Silva, Lee; And Others
TITLE	Alcohol, Tobacco, and Other Drug Use among Black Youth.
INSTITUTION	Human Sciences Research Council, Pretoria (South Africa).
REPORT NO	ISBN-0-7969-1704-3
PUB DATE	96
NOTE	167p.
PUB TYPE	Books (010) -- Reports - Evaluative/Feasibility (142)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	*Adolescents; Alcoholic Beverages; *Black Youth; Children; *Drinking; *Drug Use; Foreign Countries; *Incidence; National Surveys; Peer Influence; Prevention; Program Development; Risk; Sex Differences; *Smoking; Tobacco; Urban Youth
IDENTIFIERS	*South Africa

ABSTRACT

The Centre for Alcohol and Drug Studies, Johannesburg (South Africa) commissioned a study of alcohol, tobacco, and other drug use among historically disadvantaged black youth aged 10 to 21 years. A national survey explored the prevalence of substance use in this age group through responses of 1,376 children and youths. An in-depth study examined use patterns and attitudes among 20 black children aged 7 to 10 years, 20 aged 11 to 14 years, and 20 aged 15 to 17 years. Half of those studied were male. Results of both studies suggest a fair amount of risk for the development of alcohol and drug related problems among these young people. The use of legal drugs, including over-the-counter medicines, alcohol, and tobacco, is fairly prevalent among young people. Drinking and smoking are far more frequent among males, and seem to be part of the entry into adulthood. They are generally linked, and initiation into drinking and smoking tends to take place in uncontrolled social situations under social pressures. These findings and the potential for increased alcohol and drug related problems mean that cost-effective and innovative alcohol and drug prevention programs are needed. An appendix contains tables of study findings. (Contains 32 tables and 45 references.) (SLD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 403 368

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY
J. G. Garbers
HSRC
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Alcohol, Tobacco AND OTHER DRUG USE AMONG BLACK YOUTH

Lee Rocha-Silva; Sylvain de Miranda; Retha Erasmus

UD031482

BEST COPY AVAILABLE

ALCOHOL, TOBACCO AND OTHER DRUG USE AMONG BLACK YOUTH

ALCOHOL, TOBACCO AND OTHER DRUG USE AMONG BLACK YOUTH

Lee Rocha-Silva
Sylvain de Miranda
Retha Erasmus

HSRC Publishers
Pretoria
1996

© Human Sciences Research Council, 1996.

All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording or any information storage and retrieval system, without permission in writing from the publisher.

L. Rocha-Silva (M.A. Sociology, University of South Africa) — Centre for Alcohol- and Drug-related Research, Human Sciences Research Council
S. de Miranda (M.B. Ch.B, University of the Witwatersrand) — Centre for Alcohol and Drug Studies, Johannesburg
R. Erasmus (H.E.D.) — MarkData, Human Sciences Research Council

ISBN 0-7969-1704-3
HSRC No. 96/EJDDEB

Layout and design: Susan Smith
Cover design: Glenn Basson

Published by:
HSRC Publishers
134 Pretorius Street
0002 Pretoria
South Africa

Printed by: HSRC Printers

Notoriety of liquor

I am the most powerful
chemical mixture of liquids
I have the potential power of
dividing many families into individuals
I am liquor, I am Joala

You started drinking me when
you said you want to forget your problems
You started drinking me occasionally
and now you are drinking me professionally
Watch out! You will end up
drinking me internationally

I am liquor, the water of mentality
I will make you brave
When you are a coward
I will make you talkative if you are shy
I will land you in danger

Gone are the days when young girls
used to cook like their mothers
but nowadays they drink like their fathers

I am existing everywhere
even in churches they drink me
in the name of Holy-communion

I will make you tremble
When you are moving along the street
I will make you shiver when you are standing
I am liquor, I am Joala ...

By a 14 year-old youth

Abstract

The Centre for Alcohol and Drug Studies in Johannesburg (RSA) commissioned this study. A special attempt has been made:

- To contribute towards promoting the health and general quality of life of South African youth and particularly those in historically disadvantaged black communities in the age group of 10-21 years,
- by nationally surveying (through a house-to-house sample survey) the nature and prevalence of alcohol, tobacco and other drug intake among the relevant young people, attending also to perceptions about the acceptability of preventive services,
- thus establishing some baseline for (a) identifying alcohol and drug intake trends among South African youth, and (b) facilitating the development of national, comprehensive and research-based alcohol/drug-related preventive programmes.

A further attempt has been made to contextualize the survey findings by exploring in some depth and in a fairly open-ended manner the nature of alcohol/drug-related behaviour among a group of black children in the community of Soweto near Johannesburg.

The research suggests a fair degree of risk-proneness with regard to the development of alcohol/drug-related problems among the young people. Indeed, it seems that preventive agents need to note that:

- The use of licit drugs such as over-the-counter medicine, alcohol, cigarettes/tobacco and, to some extent, non-prescriptive sedatives, tranquilizers and stimulants is apparently fairly prevalent among young people.
- Drinking and the smoking of cigarettes/tobacco clearly differentiate in terms of gender, with both activities being especially male phenomena.
- Drinking and the smoking of cigarettes/tobacco tend to go together, and seem to be part of entry into adulthood, especially among males; the same applies to regular (at least once a week) drinking and the intake of comparatively high quantities.
- Male drinkers manifest a preference for ordinary beer and distilled spirits, whereas wine is particularly popular among female drinkers (the drinking of beer and distilled spirits by women seems to be connected with their relationships with the opposite sex).
- Spirits drinking, involving a fairly regular intake (at least once a week), seems to be quite popular, especially among male drinkers, and tends to become more prevalent with age.
- A comparatively *heavy* absolute alcohol intake and morning drinking are not altogether uncommon among drinkers, especially males, more especially the older ones.
- There is a tendency for users of cigarettes/tobacco to smoke regularly and comparatively heavily.
- Initiation into drinking/smoking of cigarettes/tobacco tends to occur in *uncontrolled* rather than *controlled* social circumstances, with friends in particular being the suppliers, although it seems that it is not uncommon for young

people to provide their first drink/cigarette/tobacco themselves.

- Reasons for the first attempt at alcohol, cigarettes/tobacco and solvents tend to be experimentation (particularly with regard to cigarettes/tobacco), pressure from friends, and fun (particularly with regard to alcohol and the comparatively older age groups, especially in rural areas and urbanized towns).
- While first experiences of alcohol seem to be positive ('nice'), the opposite applies to smoking, although the latter does not seem to act as a deterrent to trying another cigarette/more tobacco.
- Associations between drinking/smoking of cigarettes or tobacco and unfavourable biological (ill health) and social circumstances seemingly tend to influence decisions to abstain from alcohol/cigarettes/tobacco. (In the case of cigarettes/tobacco, the financial impact of such use appears to weigh fairly heavily.)
- Reasons for drinking tend to focus on mood-changing, enjoyment/fun and social pressure (in rural areas there seems to be a tendency to associate drinking with food); in the case of smoking, enjoyment/fun seems to be particularly important.
- Substances other than alcohol/cigarettes/tobacco and especially over-the-counter medicine seem to be used in order to increase energy or stamina.
- Drinking tends to take place in company and in quite *uncontrolled* social settings, where a fair degree of pressure to use alcohol can be expected — taverns/shebeens, bottle-stores and clubs/discothèques are particularly popular

drinking places among male drinkers, and the homes of friends among female drinkers.

- Smoking cigarettes is seemingly a fairly *uncontrolled* group activity (for example, the homes of friends are apparently a fairly popular place for smoking; smoking at youngsters' own homes tends to take place when parents/guardians are absent and, in the case of rural residents, schools seem to be popular).

Finally, it seems appropriate to emphasize that (a) the risk-proneness with regard to the development of alcohol/drug-related problems (including HIV infection/AIDS) at various levels among young black South Africans, (b) the present rather unstable economic climate in South Africa, and (c) the public health implications of a future increase in alcohol/drug-related problems (including HIV infection/AIDS) among the youngsters create great pressure for *cost-effective and innovative alcohol and drug-related prevention programmes*.

Ekserp

Hierdie studie is uitgevoer in opdrag van die Sentrum vir Alkohol- en Dwelm-studies in Johannesburg (RSA). 'n Besondere poging is aangewend

- om by te dra tot die bevordering van die gesondheid en algemene lewensgehalte van die Suid-Afrikaanse jeug en in die besonder diegene in tradisioneel agtergeblewe swart gemeenskappe in die ouderdomsgroep 10-21 jaar,
- deur middel van 'n nasionale opname (deur 'n huis-tot-huis steekproef) rondom die aard en voorkoms van alkohol/dwelmgebruik onder die betrokke jongmense, terwyl aandag ook gegee is aan persepsies omtrent die aanvaarbaarheid van voorkomingsdienste,
- om op hierdie wyse 'n basis daar te stel vir (a) die bepaling van tendense ten opsigte van alkohol, tabak en ander dwelmgebruik onder die Suid-Afrikaanse jeug, en (b) die ontwikkeling van nasionale, omvattende en wetenskaplik gefundeerde alkohol/dwelmverwante voorkomingsprogramme.

'n Poging is ook aangewend om die opnamebevindings in 'n mate te kontekstualiseer deur die aard van alkohol/dwelmverwante jeuggedrag onder 'n groep swart kinders van die Soweto-gemeenskap van Johannesburg taamlik grondig en op 'n oop manier te ondersoek.

Die navorsing dui aan dat daar 'n redelike risiko is met betrekking tot die ontwikkeling van alkohol/dwelmverwante probleme onder die jongmense. Dit lyk inderdaad of voorkomingsagente daarop moet let dat:

- Die gebruik van wettige dwelms soos toonbankmedisyne, alkohol, sigarette/tabak en, in 'n mate, nie-voorgeskrewe susmiddels, kalmeermiddels en opkikkers oënskynlik taamlik algemeen onder jong mense is.
- Drink en die rook van sigarette/tabak differensieer duidelik in terme van geslag — albei aktiwiteite word veral onder jongmense aangetref.
- Drink en die rook van sigarette/tabak neig om saam gebesig te word, en skyn deel te wees van toetrede tot volwassenheid, veral onder jong mans; dieselfde geld vir gereelde (ten minste een maal per week) drankgebruik en die inname van taamlik groot hoeveelhede.
- Manlike drinkers toon 'n voorkeur vir gewone bier en spiritualieë, terwyl wyn besonder gewild is onder vroulike drinkers (die drink van bier en spiritualieë deur vroue hou skynbaar verband met hul verhoudings met die teenoorgestelde geslag).
- Die drink van spiritualieë, en dan 'n taamlik gereelde inname (ten minste een keer per week) skyn taamlik algemeen te wees, veral onder manlike drinkers, en neig om toe te neem met ouderdom.
- 'n Taamlik *swaar* inname van absolute alkohol en oggenddrink is nie heeltemal ongewoon onder drinkers nie, veral onder jong mans en dan in die besonder die oueres.

- Daar is 'n geneigdheid onder sigaret/tabakgebruikers om gereeld en taamlik swaar te rook.

- Die intrede tot drank/sigaret/tabakgebruik neig om plaas te vind tydens *ongekontroleerde* eerder as *gekontroleerde* sosiale samekomste waar veral vriende die verskaffers is, hoewel dit skynbaar nie ongewoon vir jongmense is om hul eerste drankie/sigaret/tabak self te bekom nie.

- Redes vir die neem van die eerste alkohol/sigaret/tabak en oplosmiddels neig te wees eksperimentering (veral in die geval van sigarette/tabak), druk van vriende, en plesier (veral met betrekking tot alkohol en die ouer ouderdomsgroepe in die landelike omgewings en verstedelikte dorpe).

- Terwyl eerste ervarings met alkohol skynbaar positief beleef word (*'nice'*), geld die teenoorgestelde ten opsigte van rook, hoewel laasgenoemde ervarings skynbaar nie as afskrikmiddel vir die verdere gebruik van sigarette/tabak dien nie.

- Die verhouding tussen drink/rook van sigarette/tabak en ongunstige biologiese (swak gesondheids) en sosiale omstandighede neig skynbaar om weerhouding van die gebruik van alkohol/sigarette/tabak te bevorder (in die geval van sigarette/tabak weeg die finansiële impak van gebruik taamlik swaar).

- Die redes vir drankgebruik fokus op gemoedsverandering, genot/plesier en sosiale druk (in die landelike gebiede is daar 'n neiging om drankgebruik met kos te assosieer); in die geval van rook skyn genot/plesier veral belangrik te wees.

- Stowwe anders as alkohol/sigarette/tabak en veral toonbankmedisyne word skynbaar gebruik om energie en stamina te verskaf.

- Alkohol neig om gebruik te word in geselskap en in taamlik *ongekontroleerde* sosiale omstandighede waar daar 'n redelike mate van druk verwag kan word om alkohol te gebruik — kroeë/sjebeens, drankwinkels en klubs/diskoteke is veral gewild as drinkplekke onder manlike drinkers, en die huise van vriende onder vroulike drinkers.
- Die rook van sigarette is skynbaar ook 'n taamlik *ongekontroleerde* groepaktiwiteit (die huise van vriende is byvoorbeeld oënskynlik 'n taamlik gewilde plek vir rook, rook by die jeugdiges se eie huise neig om te geskied in die afwesigheid van die ouers/voogde, en in geval van landelike mense skyn skole gewilde plekke te wees).

Dit skyn in die laaste instansie gepas te wees om te benadruk dat (a) die aanduidinge dat daar 'n risiko is met betrekking tot die ontwikkeling van alkohol/dwelmverwante probleme (insluitend HIV-infeksie/VIGS) op verskeie vlakke onder jong swart Suid-Afrikaners, (b) die huidige taamlik onstabiele ekonomiese klimaat in Suid-Afrika, en (c) die openbare gesondheidsimplikasies van 'n toekomstige toename in alkohol/dwelmverwante probleme (insluitend HIV-infeksie/VIGS) onder die jeug, groot druk meebring vir *koste-effektiewe en vernuwende alkohol/dwelmverwante voorkomingsprogramme.*

Acknowledgements

Many persons were involved in conducting this research and their contributions and assistance are gratefully acknowledged:

◆ The *Department of National Health (Health Promotion)*, as well as the *Department of Welfare (Family and Community Care)* without whose financial support this research would not have been possible;

◆ Members of the research committee:

Sylvain de Miranda — chairperson (Centre for Alcohol and Drug Studies, Johannesburg, South Africa) who specializes in alcohol/drug-related prevention programmes among young people; Stephanie Brewis (Subdirectorate Family and Community Care, Department of Welfare, Pretoria, South Africa); Neels Ehlers (Health Promotion, Department of Health, Pretoria, South Africa); Johannes Lehutjo (Markdata, Human Sciences Research Council, Pretoria, South Africa); Maseka Lesaoana (South African Data Archive, Human Sciences Research Council, Pretoria, South Africa); Isodore Obot (Centre for Research and Information on Substance Abuse, University of Jos, Nigeria); Martin Plant (Alcohol Research Group, University of Edinburgh, Scotland); Ronel Sartor (Centre for Alcohol and Drug Studies, Johannesburg, South Africa); Johann Schoeman *ad hoc* member (Department of Psychology, University of Pretoria, Pretoria, South Africa; Dawie Stoker (Statomet, University of Pretoria, Pretoria, South Africa); Yussuf Saloojee *ad hoc* member (South African National Council Against Smoking, Johannesburg, South Africa); Patience Tshabalala (Centre for Alcohol and Drug Studies, Johannesburg, South Africa); Murray van der Merwe (MarkData, Human Sciences Research Council, Pretoria, South Africa);

- The young people who agreed to take part in the research;
- The interviewers without whose dedication and expertise the research would not have been possible.

The authors
May 1995

Foreword

With the completion of this 1994 national South African youth survey, various milestones have been reached:

- It is the first alcohol- and drug-related youth research project supported by the new, democratically elected South African Government (Department of Health, Directorate Health Promotion).
- It is the first South African youth research project surveying young people from the age of ten years upwards.
- For the first time, both qualitative (focus groups) and quantitative (survey) research findings are combined in order to evolve a comprehensive pattern.
- The combination of pure research with grassroot practitioner expertise will result in the development of meaningful practical intervention strategies.
- It has aroused the interest of researchers both in Africa and abroad, thereby laying the foundation for many conjoint developments which may well lead to innovative and dynamic universal approaches.
- Its focus on disadvantaged youth will contribute to more realistic strategies than the present hypothetical paternalistic theoretical approaches have done.

This study underscores my belief that, wherever they find themselves in this world, children are still children, regardless of race, creed and culture.

Finally, tribute is due to the individual research committee members whose guidance, knowledge, objectivity, perseverance and determination have made this research project a major South African contribution to world knowledge. A personal thank you to Lee Rocha-Silva for her advice and willingness to share her knowledge with me.

Dr Sylvain de Miranda
Johannesburg
May 1995
South Africa

Contents

Section 1 Introduction 1

Background 3

Research objectives 6

Theoretical framework 7

Technical research matters 9

Section 2 In-depth (qualitative) study on behaviour of young people (10-21 years) 15

Introduction 17

Focus groups 17

Methodology 17

Results 19

- Age group 7-10 years (Group I) 19
- Age group 11-14 years (Group II) 21
- Age group 15-17 years (Group III) 22
- Comparison of interaction across age groups 24

Discussion 26

Case studies 27

- Case study 1 27
  - Introduction 27
  - Background information 27
  - Problem and drinking history 28
  - Progress at Streetwise shelter 29

Conclusion 30
Case study 2 30
Introduction 30
Background information 31
Drugging history 31
Progress in rehabilitation 31
Conclusion 32
Case study 3 32
Introduction 32
Background information 32
Drugging history 33
Progress in treatment at the Centre 34
Conclusion 35
Summary 36

Section 3 Survey findings 39
Level of alcohol, tobacco or or other drug intake 41
Level of intake with regard to substances other than alcohol 49
First attempt at using alcohol, tobacco or other drugs 52
Reasons for using or abstaining from alcohol, tobacco or other drugs 55
Context within which alcohol, tobacco and other drugs are used 58
HIV infection/AIDS-related matters 61

Section 4 Discussion: Areas of risk related to alcohol, tobacco and other drugs 63
Introduction 65
Level of alcohol consumption 66

Level of intake of tobacco and drugs other than alcohol 69

First use of alcohol, tobacco and other drugs 71

Reasons for using or not using alcohol, tobacco and other drugs 73

Context within which alcohol, tobacco and other drugs are used 75

Summary 77

Section 5 Closing remarks: Preventive guidelines 83

Background 85

Recommendations 86

Prevention focuses 88

Behavioural and social interactional factors 88

Attitudinal factors 89

Prevention goals 89

Demand reduction 89

Availability reduction 90

Bibliography 93

Appendix A – Tables 97

List of tables

Table 1 Honesty-screening responses in terms of place of residence 99

Table 2 Honesty-screening responses in terms of gender 100

Table 3 Honesty-screening responses in terms of age 102

Table 4 Honesty-screening responses in terms of church attendance 103

Table 5 Drinking status of 10-21 year olds: Black communities in the RSA (1994) 105

Table 6 Drinking status of blacks in the RSA and the self-governing states (14 years and older) (1990), as well as in Gauteng (18-64 years old) (1990, 1985, 1982) 106

Table 7 Type of alcoholic beverages consumed by 10-21 year olds: Black communities in the RSA — current drinkers (1994) 107

Table 8 Type of alcoholic beverages consumed by blacks in the RSA and the self-governing states (14 years and older) (1990), as well as in Gauteng (18-64 years old) — current drinkers (1990, 1985, 1982) 108

Table 9 Drinking frequency (per alcoholic beverage) of 10-21 year olds: Black communities in the RSA — current drinkers (1994) 109

Table 10 Drinking frequency of blacks in the RSA and the self-governing states (14 years and older) (1990), as well as in Gauteng (18-64 years old) — current drinkers (1990, 1985, 1982) 110

Table 11 Annual quantity (litres) consumed per alcoholic beverage by 10-21 year olds: Black communities in the RSA — current drinkers (1994) 111

Table 12 Annual quantity (litres) consumed by blacks in the RSA and the self-governing states (14 years and older) by type of beverage consumed — current drinkers (1990) 112

Table 13 Total annual quantity (litres) of absolute alcohol consumed by 10-21 year olds: Black communities in the RSA — current drinkers (1994) 113

Table 14 Total annual quantity (litres) of absolute alcohol consumed by blacks in the RSA and the self-governing states — current drinkers (1990) 114

Table 15 Use of substances other than alcohol by 10-21 year olds: Black communities in the RSA — current users (1994) — 'Yes' responses 115

Table 16 Use of substances other than alcohol, tobacco, dagga, white pipe (mixture of dagga and mandrax): 10-21 year olds in black communities in the RSA (1994) — 'Yes' responses to set questions 116

Table 17 Use of substances other than alcohol by blacks in the RSA (14 years and older) — current users (1990) 117

Table 18 Frequency (per substance) with which substances other than alcohol are used by 10-21 year olds: Black communities in the RSA — current users (1994) 118

Table 19 Frequency with which substances other than alcohol are used by blacks in the RSA (14 years and older) — current users (1990) 119

Table 20 What current smokers smoke and the quantity of use among 10-21 year olds: Black communities in the RSA (1994) 120

Table 21 First use of various substances by 10-21 year olds: Black communities in the RSA (1994) 121

Table 22 Reasons for not using alcohol/cigarettes/tobacco given by 10-21 year olds: Black communities in the RSA (1994) — current users 125

Table 23 Reasons for drinking and using other substances given by 10-21 year olds: Black communities in the RSA (1994) — current users 127

Table 24a Reasons for drinking and drugging given by blacks in the RSA (14 years and older) — current users (1990) 131

Table 24b Reasons for drinking and drugging given by blacks in the former self-governing states — current users (1990) 133

Table 25 Context within which alcohol and other drugs are used by 10-21 year olds: Black communities in the RSA (1994) — current users 135

Table 26 Context within which alcohol and other substances are used by blacks in the RSA and the self-governing states (14 years and older) — current users (1990) 138

Table 27 Experiences related to the use of alcohol, tobacco and other drugs by 10-21 year olds: Black communities in the RSA (1994) — current users 141

Table 28 Drinking-related experiences of blacks in the RSA and the self-governing states (14 years and older) — current drinkers (1990) 142

Table 29 Social pressure to use various substances as experienced by 10-21 year olds: Black communities in the RSA (1994) 143

Table 30 Demand for and access to alcohol among blacks in the RSA and the self-governing states (14 years and older) (1990) 145

Table 31 Knowledge and acceptability of alcohol/drug-related services of 10-21 year olds: Black communities in the RSA (1994) — 'Yes' responses 146

Table 32 Responses to AIDS-related matters given by 10-21 year olds: Black communities in the RSA (1994) 147

Section 1

INTRODUCTION

Background

The negative impact that alcohol-, tobacco- and drug-related practices may have on health, economic growth, social relationships, community life and emotional and spiritual well-being is widely acknowledged. Indeed, drinking, smoking and drug-taking patterns and trends in a community are frequently used as a fairly reliable general indicator of the quality of life in that community (Tucker & Scott, 1992:108-110).

Of particular concern is that history in Africa and the wider world has shown that when a country is experiencing general and drastic socio-economic changes, as is the case in South Africa at present, these frequently reverberate within the sphere of alcohol/drug intake. It seems that various alcohol-, tobacco- and other drug-related problems often develop and escalate in the wake of such changes, draining scarce and key human and other resources, marginalizing people, impeding socio-economic growth and, as some African sociologists suggest, *replacing social relationships* and *dehumanizing* people (Kuna & Bande, 1993; Obot, 1993a, 1993b; Molamu, 1988; Beckman, 1988; World Health Organization, 1980, 1992).

In fact, national longitudinal data in South Africa (Rocha-Silva, 1992) suggest that regarding alcohol and drug practices major changes are taking place. Particularly disturbing are indications of a progressive increase in the general level of drug, and more especially alcohol, intake among adults, specifically in historically disadvantaged black communities and among women generally (Rocha-Silva, 1991a, 1992). (Detailed national baseline data regarding alcohol/drug intake among young South Africans are lacking. However, experience in other African and overseas countries has shown that the proportion of alcohol/drug users among this segment of the population grows as the general level of intake among adults in the community increases (World Health Organization, 1980, 1995; Davies & Walsh, 1983).)

Moreover, with increasing opportunities for South Africans to participate in international trade and travel and for international illicit drug traffic networks to penetrate the local market, the proportion of alcohol/drug users and, indeed, the general level of alcohol/drug intake can only be expected to rise in the near future. This is a source of grave anxiety as there is overwhelming evidence that *the general level of alcohol/drug intake in a community co-varies with the general level of related problems in that community* (Frankel & Whitehead, 1981). Indeed, even as South Africans are repositioning themselves toward *health for all* and, most importantly, toward a *life of quality for all*, a progressive increase in the general level of alcohol/drug intake in this country may render their efforts futile. This danger is recognized in the World Health Organization's (WHO) 1992 progress report on their Substance Abuse Programme where the point is made that

> ... measures to reduce alcohol and drug abuse [should be] ... seen as essential to a country's programme of national economic development; ... efforts to combat alcohol and drug abuse [should] become part of a nation's positive drive to achieve its full potential (WHO, 1992:6).

In fact, the above scenario underscores the need for alcohol/drug-related preventive programmes among South African youth. After all, they constitute a major proportion of the South African population; and they represent the future. The impairment of their psycho-social development through *inter alia* alcohol/drug intake could be disastrous. That special attention needs to be given to young people, specifically adolescents from historically disadvantaged groups in South Africa, and black youth in particular, is clear. Mostert and Van Tonder (1987) estimate that at present adolescents (10-21 year olds) in the latter group represent approximately 21,0 per cent of all South Africans, and more or less 82,0 per cent of South Africans in the age group 10-21 years.

However, rational and cost-effective alcohol/drug-related preventive programming and, indeed, the monitoring of preventive initiatives are hampered through a *lack of updated national baseline information* on the nature and prevalence of alcohol/drug intake. This lack specifically applies to black South African youth.

The Human Sciences Research Council's Centre for Alcohol- and Drug-related Research was consequently commissioned by the Centre for Alcohol and Drug Studies in Johannesburg to conduct a *national sample survey on alcohol/drug practices and related matters among 10-21 year olds in black households in South Africa.* To ensure the relevance, the sophistication and the applicability of the research, to facilitate the widest possible implementation of the findings and to enable the mapping of South Africa within the wider African, and to some extent the international, context, a multisectoral committee (*inter alia* representing major local stakeholders in the private and public sector) acted as a consultative body in the course of the planning and execution of this survey.

Research objectives

A special attempt has been made:

- To contribute towards promoting the health and general quality of life of South African youth in the age group 10-21 years, and particularly those in historically disadvantaged black communities,
- by conducting a national survey (by means of a sample survey), as detailed as possible, of the nature and prevalence of alcohol, tobacco and other drug intake among the relevant young people, paying attention also to perceptions about the acceptability of preventive services,
- in order to (a) identify areas of risk regarding the development of alcohol, tobacco and drug-related (health) problems, and (b) gauge the extent to which the youth are aware of and willing to use preventive services,
- thus (a) establishing some baseline for monitoring alcohol/drug intake trends among South African youth, and (b) facilitating the development of national, comprehensive and research-based alcohol, tobacco and other drug-related preventive programmes.

Some attempt was also made to contextualize the survey findings by exploring in some depth and in a fairly open-ended manner the nature of alcohol, tobacco and other drug-related behaviour among a group of black children in a geographically more restricted area, namely the community of Soweto near Johannesburg. In this way it was hoped to refine the survey findings.

Special note should be taken that, in view of alcohol/drug use and particularly the comparatively *heavy* use being widely recognized as potentially risky in terms of contracting and transmitting the HI virus; and by reason of the fairly widely accepted value of the educational mode of intervention, some attention was given to HIV infection/AIDS-related matters. (Practical difficulties, such as the possibility of concentration loss and of *overloading* the questionnaire with fairly sensitive matters, prevented the gathering of detailed information on HIV infection/AIDS. Indeed, the focus was on gauging the young peoples' level of knowledge with regard to the nature of AIDS and the extent to which they felt a need for relevant information. The matter of whether the respondents had ever been tested for HIV infection/AIDS and the results of the tests were also investigated.

Theoretical framework

The relevant project was driven by a Public Health Model of prevention as articulated by the WHO (World Health Organization, 1980). A particular advantage of this model is its multi-facetedness. It was supplemented by the South African orientated Rocha-Silva Model of prevention research (Rocha-Silva, 1992).

The Public Health Model takes cognizance of the agent, the host and the environment in which these operate. The model argues that alcohol/drug-related problems (and especially health risks) will manifest in a community, to the extent to which there is a demand for these substances and in so far as they are available. The Rocha-Silva Model elaborates on and interrelates the areas of concern in the Public Health Model within the sphere of sociological theory of human behaviour in general, sociological theory of deviance and

South African research on the nature and development of *alcoholism* which, by implication, means alcohol/drug use in general.

In brief, major assumptions of the Rocha-Silva Model are that social factors, such as support for alcohol, tobacco and other drug use, access to these substances, an absence of discrimination against their use and exposure to such use, as well as psychological factors, such as knowing about alcohol/drug use, not expecting discrimination in case of use, being tolerant towards such use and a personal attraction to taking or using them, contribute to the occurrence of alcohol/drug use, and consequently to related problems including health risks.

In fact, in terms of the above assumptions, information was accumulated on the following matters in order to identify areas of risk regarding the development of alcohol/drug-related problems:

- Level of alcohol/drug intake;
- settings/context in which and times when alcohol/drugs are used;
- reasons why alcohol/drugs are used;
- bio-psycho-social experiences in the course of or before/after alcohol/drug intake;
- the extent to which the persons concerned experience an environmental demand for alcohol/drugs, as well as access to alcohol/drugs;
- knowledge of and the acceptability of alcohol/drug-related prevention/treatment services.

Technical research matters

Generally, note should be taken that financial restrictions, the national scope of the study and a concern with a variety of aspects limited the *sample* size (1 376). (A larger sample would, however, have facilitated detailed regional analyses.) Provision was made for representation of black South Africans in the age group 10-21 years in the major metropolitan centres, towns and informal settlements bordering on the metropolitan centres, as well as fairly deep-rural sectors (the former self-governing states and TBVC[1] states). Blacks in hostels and on farms were excluded. A multi-stage stratified cluster or complex sample was drawn, with the 1991 population census as sampling frame.

A largely closed-ended *questionnaire* was administered in *face-to-face interviews by experienced fieldworkers,* mostly women. Special attention was given to their abilities to establish rapport with young children. Most importantly, *senior service providers* specializing in alcohol/drug-related prevention/treatment among the young of the Centre for Alcohol and Drug Studies *assisted with the preparation and detailed training of the fieldworkers,* who were required to make a special effort to give respondents concrete assurance of the *confidentiality* of their responses. Interviews were conducted in private. Verbal or written permission was obtained from the head of a sampled household for interviewing the randomly selected young person in the household.

---

[1] Transkei, Bophuthatswana, Venda and Ciskei.

With the exception of some areas in the Eastern Transvaal, fieldworkers were fairly well received in the various regions. Extensive negotiation with community leaders enabled the fieldworkers to gain access to those communities who at first were not willing to receive them. In certain communities, randomly selected households had to be substituted according to predetermined principles because of a concentration of households with either no children or children below the age of ten. Nevertheless, a 100,0 per cent response rate was obtained.

In the light of the emphasis on placing the research findings within the wider South African, and to some extent international, context, a special attempt was made to provide for *comparability* in the construction of the questionnaire. The representatives from Africa and overseas on the research committee made a major input here. The South African service providers on the committee monitored the relevance and refinement of the questionnaire in terms of the South African context.

In order to avoid concentration difficulties on the part of the respondents, care was taken to construct a questionnaire that would need a maximum of 30 minutes to complete. This time restriction and the need (expressed by some of the research committee members) to address, to some extent, HIV infection/AIDS-related matters resulted in the scaling down of some of the matters concerned. Certain issues were dealt with in the questionnaire in a less detailed manner than originally planned. In fact, the emphasis was on alcohol and, to a lesser extent, cigarettes/tobacco rather than on other psycho-active substances. (Reports from preventive/treatment agents and related local research (Flisher *et al.*, 1993) suggest that alcohol and cigarettes/tobacco are generally the substances most commonly used by young people and frequently manifest as stepping stones towards multiple substance use. Studies in other African countries (Obot, 1993b) bear this out.) Concern on the part of service providers regarding the possibility that sniffing/snorting of solvents, the smoking of dagga and white pipe (mixture of mandrax and dagga) are also fairly prevalent among young people, influenced the decision to give more attention to these substances than to the others (excluding alcohol and cigarettes/tobacco).

A special attempt was made to construct individual questions according to the same format to ease administration and response flow. This especially applied to the sections on the frequency and quantity of alcohol/drug intake. In fact, the format of the Khavari Alcohol Test (KAT)[2] was used as a basis in the latter respect.

The decision to use the KAT in the present study was based on the following factors. It has been extensively used in past research on the drinking practices of adults in particular and, to some extent, young adults in South Africa and thus provides a basis for monitoring intake trends. Moreover, the KAT provides ample opportunity for checking the internal consistency of responses on intake. Not only is it quite easily administered, but it also uses a quantity-cum-frequency index of alcohol intake that is more detailed than most of the other indices that have been used in this respect. Thus, in addition to being quite sensitive to differences in level of intake, it facilitates memory recall and accuracy, the lack of which contaminates inference in research into alcohol/drug practices.

---

[2] For a detailed outline of the nature and value of the KAT, see: Rocha-Silva, L. 1987. Towards a more detailed measurement on quantity and frequency of alcohol intake of whites in the Republic of South Africa. *South African Journal of Sociology*, 18(4):133-138.

The KAT's interval quantification facilitates a detailed, statistical and empirical identification of various types of drinkers in terms of the quantity and frequency of consumption of various alcoholic beverages by contrast with the frequent tendency of related research to classify drinkers into fairly arbitrarily predefined nominal classes, such as light, moderate and heavy drinkers. In this way, the limited generalizability (and thus limited scientific usefulness) of many quantity-cum-frequency measures of level of alcohol intake is, to some extent, overcome. Indeed, the KAT's detailed interval measurement of quantity-cum-frequency of alcohol intake provides a firm empirical base for policy making in the field of prevention. It should also be noted that, apart from enabling a beverage-by-beverage analysis of frequency, quantity and quantity-cum-frequency of alcohol intake, the KAT measures variation in a respondent's pattern of intake over a particular period. Another advantage is that it includes questions on alcohol intake that parallel those used in most other quantity/frequency indices of level of alcohol intake.

Over and above the use of these mechanisms for quality control, five statements were put to the respondents at the end of the questionnaire to test, to some extent, their general level of integrity, namely:

> 'I would rather win than lose a game';
> 'I have never told a lie, not even a tiny one';
> 'I do not like everyone I know';
> 'At times I have felt like swearing';
> 'If I could get into a movie without paying and be sure I would not be caught, I would probably do it'.

An analysis of the responses to the relevant statements suggested that the *majority of the respondents most probably* *acted with a fair level of integrity.* Indeed, 88,0 per cent of the respondents said that it was true that they would rather win than lose a game: 66,0 per cent said that it would be false to say that they had never told a lie, not even a tiny one; and 56,0 per cent pointed out that it would be true to say that at times they had felt like swearing. The statement that relates to *movies* might possibly not have been relevant to a major part of the respondents — a substantial proportion (11,0 per cent) were uncertain as to what to reply or did not reply.

Concerning the matter of *validity* in general, it should be noted that it is widely acknowledged that all data-gathering instruments have built-in validity problems. Survey questionnaires, whether self-completed or administered through face-to-face interviews, are no exception, and particularly so studies on drinking/drug taking among adolescents (Fossey, 1994; Loretto, 1994; May, 1992). However, as noted by Fossey (1994:28),

> ... in spite of ... difficulties, surveys ... have provided valuable insight into the nature of the phenomenon of youthful drinking, from both a regional and a national perspective. Furthermore, these studies have examined a wide range of factors relating to adolescent alcohol use. ... What is most important, though, is to recognize and explicitly acknowledge that survey ... [and, in fact, ethnographic] research can never determine the distribution of alcohol [and other drug] use ... in any absolute sense across the 'young' population as a whole (May, 1992:110).

At best, surveys identify cross-sectional and longitudinal *trends/patterns*. Moreover, *convergence of several lines of independent evidence* is fairly widely supported as an indication of an adequate level of quality control (Jessor *et al.*, 1968:137-149; Kerlinger, 1973:462). In fact, logical consistency between various sets of independently gathered information and between various response sets in, for example, a particular study/survey, is heavily leaned on as a criterion for accepting the integrity of, for example, survey data. Consequently, in the present study, special emphasis was placed on comparisons, within the present data set, as well as between the latter and related South African (especially the HSRC's earlier methodologically comparable national surveys among largely South African adults) and overseas studies. In fact, a special attempt was made to identify trends across related studies and thus to place or map the findings within the broader context of local and overseas research.

Section 2

In-depth (qualitative) study on behaviour of young people (10-21 years)

Introduction

This section qualitatively explores, in some depth and through focus groups and case studies, alcohol- and drug-related behaviour of young people. In this way, it is hoped, a fuller contextual background to the quantitive findings of the national survey that was conducted will be provided. Briefly, note was taken of the following:

> Qualitative research is a particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language, on their own terms ... qualitative research has been seen to be 'naturalistic', 'ethnographic' and 'participatory'; ... quality connotes the 'nature', as opposed to the 'quantity' or amount of a thing (Kirk & Miller, 1986).

It is important to note that in subsequent sections the insights that surfaced in the course of the focus group sessions and case studies will be related to the major findings of the national survey. A special attempt will be made to explore the extent to which the qualitative and quantitive findings substantiate and refine one another.

Focus groups

Methodology

The sample was made up of black children resident in the predominantly black urban area of Soweto. Three age groups were represented:

- Group I: 20 children (ten boys and ten girls) between the ages of seven and ten years;
- Group II: 20 children (ten boys and ten girls) between the ages of 11 and 14 years; and
- Group III: 20 children (ten boys and ten girls) between the ages of 15 and 17 years.

In all three groups, school-going and non-school-going children were equally represented. The group sessions were held in observation rooms with one-way mirrors, and educational psychologists and a remedial teacher observed the proceedings from behind these mirrors.[3]

The approach was mainly non-directive. Children were left to structure their activities themselves, for the first half of each session.[4] Thereafter, one of the observers entered the room and facilitated, in a non-intrusive way, the exploration by the children of various aspects of substance abuse, including types of drugs available and the effects of various substances. No information regarding the dangers of substance abuse was provided at this stage, as it was essential that the children express freely their ideas and experiences, and that this was in no way influenced by the observer.

---

[3] Observers:
Daphne Ramokhoase (Diploma Remedial Education)
Fiona Geddes (Educational Psychologist)
Louise Johnson (Educational Psychologist)
Poppy Thabethe (M.Ed. School Counselling)

[4] Equipment included:
Closed-circuit television equipment, telephone, chairs, wax crayons, koki pens, pencils, blank paper, two balls, soft toys (including a dog, a doll and an elephant), miniature set of baby, pram, dummy, bottle, cot, set of building blocks, plastic truck, toy cars, sweet cigarettes, empty glass bottle.

Each group was seen on a separate afternoon. Three sessions were held each afternoon:

- An hour long session with the girls;
- an hour long session with the boys; and
- an hour long session with a mixed-sex group (five boys and five girls, randomly selected from the original groups).

Results

Age group 7-10 years (Group I)

Comparison of the interaction of the all-boy and all-girl groups

Some differences in general attitude were evident. Girls entered the room more hesitantly than boys, who seemed instantly at home in the environment. The boys were generally more noisy than the girls. Although both groups seemed aware that they were being observed, and both, to some extent, *played to the audience* and acted in front of the mirror, only the girls seemed to *sensor* their behaviour to any extent. They were, for example, hesitant to take the *cigarette* sweets (hard candy in the shape of cigarettes) and distribute them among themselves.

Only three of the girls actually *smoked* these cigarettes, whereas almost all of the boys did. The boys seemed to enjoy watching themselves in the mirror while they did this.

Responses to the toys available also differed. Although boys as well as girls were attracted to the dolls and soft toys, the girls demonstrated *nurturing type behaviour*, whereas the boys generally used these toys as balls. The girls did on occasion play with the balls and trucks, but the boys' attention was devoted mainly to the latter toys.

The behaviour of the boys was more energetic, vigorous and daring than that of the girls. The boys, for example, seemed to need to wear their identifying labels on their foreheads (and not on their shirts), and their soccer games involved dramatic dives and lunges. War games and boxing also featured in the games of the boys.

Boys and girls were both engaged in drawing and dancing. A significant difference between the behaviour of the two groups was that in the girls' group, one girl assumed a *caretaker* role, guiding the others in their activities and often playing *teacher*, even meting out physical punishment to the others.

In both groups, one individual seemed to be isolated and excluded. The girls seemed to interact in a more organized fashion, using structured interaction such as class-room scenarios and singing contests, and actively sharing the toys. The boys did not share as easily, and conflict arose from time to time in this regard. The boys also seemed to become bored and frustrated after a while. This was not evident among the girls.

During the discussions on drugs, fewer differences emerged. Drugs known by the boys and girls included dagga (marijuana), benzine, *brown pills*, glue, beer, mandrax (methaqualone), and *bottel kops* (a mixture of marijuana and mandrax, usually smoked in a bottle neck). Boys and girls both stated that they had seen relatives using the substances. Only one boy, and no girls, reported ever having used a substance (beer). Boys mentioned no known brand names. Girls mentioned brandy and *Hunters Gold* (apple cider). The boys mentioned that when boys were under the influence of substances they were likely to rape. They expressed no negative judgement about this and seemed to feel that perpetrators would not face any negative consequences as a result of such behaviour.

Significant factors emerging from mixed-group interaction

The noise level of this group seemed much lower than in the separate-sex groups. The boys still engaged in vigorous soccer games, the girls played with the dolls and engaged in drawing. The girls were often hit with soccer balls. The girl who had emerged as leader in the all-girl group again played a *protector* role, trying to usher the girls out of harm's way. After about 15 minutes, the boys occupied about 75 per cent of the available floor space.

The girls largely ignored the boys, and their own group seemed to form a closer unit. One striking difference was that the girls interacted largely verbally, whereas the boys interacted largely through throwing balls (and other objects) at one another. The vigorousness of the boys' game seemed to be heightened by the presence of the girls.

Age group 11-14 years (Group II)

Comparison of the interaction of all-boy and all-girl groups

Very little of the activity in either group centred around the available toys. Although the boys did play some soccer games, and inspected some of the toys, the girls paid almost no attention to the toys at all. On entering the room, the girls seemed very excited, whereas the boys appeared to be more puzzled at the activity.

The activities of the girls seemed to centre around beauty and fashion. They were very aware of the mirror, and spoke a lot about beauty contests. They modelled in front of the mirror and seemed very absorbed in self-observation. A leader emerged, who spent some time playing *teacher*. The interaction of the boys was more energetic and physical. After initially seeming not to know what to do, and sitting around the room, they started playing soccer, appearing very competitive in showing off their skills.

Their interaction was mainly non-verbal, whereas the girls spent a lot of time discussing girls from other schools, their mode of dress and their *promiscuity*. Overall, the girls seemed to forge a more unified group than did the boys.

The *cigarettes* were *smoked* by both the girls and the boys. The boys appeared more eager to *venture* in terms of playing the music, altering the volume and playing with the telephone. No formal group discussion occurred in this group.

Significant factors emerging from mixed-group interaction

During this session, girls and boys mingled, with a lot of the girls actively seeking out the company and attention of the boys, and *vice versa*. A lot of interaction occurred through soccer games, and it seemed that the girls and boys who had been more extrovert in the original groups, were the main players.

The rest of the individuals sat around on the periphery, observing the soccer game. There was very little verbal interaction. No formal group discussion occurred in this group.

Age group 15-17 years (Group III)

Comparison of the all-boy and all-girl groups

Both the group of boys and the group of girls seemed largely to ignore the available toys. The girls played some soccer, but showed no interest in the other games. The boys actively explored the room, including the closed-circuit equipment and the one-way mirror. The boys switched on the music and danced, whereas the girls hesitated to touch the tape recorder, seeming anxious about the response of the observers.

Until the discussion began, the activities of the boys and girls seemed very disjointed and asocial. The girls enacted fashion modelling, watching themselves continuously in the mirror. Some girls placed soccer balls under their jerseys and played at being pregnant, watching themselves with apparent fascination in the mirror.

Boys again mentioned that rape occurred when people were under the influence of substances. Girls also mentioned that they needed to stay out of the way of boys who were intoxicated, as they may be raped. Girls discussed pregnancy, *mental* problems and getting a bad name as possible consequences of rape. Girls stated that females became promiscuous while under the influence of substances.

Known drugs included mandrax (methaqualone), cocaine, dagga (marijuana), glue, benzine, white pipes (a mixture of dagga and mandrax), *appletizer and disprin*, tobacco and alcohol. Girls admitted to having used tobacco and alcohol, and boys admitted to having used benzine, *bottel kops*, alcohol and tobacco. Boys, as well as girls, stated that they bought these substances for themselves. Boys and girls reported seeing violent crimes committed by people under the influence of substances, including vandalism, shooting and people being set alight.

Boys and girls mentioned some consequences of the use of substances, for example, alcohol-induced feelings of weakness, dizziness and bad behaviour. Boys reported vivid hallucinations resulting from the use of mandrax and benzine. The boys stated that they had difficulty believing that girls would use any of these substances. The only brand name used by the boys was *Peter*

Stuyvesant, apparently known as *the school boy's cigarettes*. Girls named *Rothmans*, *Smirnof,*' (vodka), and *Hunter's Gold*.

Significant factors emerging from mixed-group interaction

Interaction in the mixed group was entirely formal. Girls and boys discussed drugging, contributing equally to the conversation. During this discussion, very few negative effects of drugging were mentioned. These were limited to drugs killing brain cells, and drugs *condemning* people (unfortunately this idea was not further explored). A lot of time was spent discussing the virtues of substances. Dagga was believed to help people lose weight, make them strong, energetic and clever, help them relax and feel sleepy, give them extra-sensory knowledge, and protect them from physical harm ('if one is hit on the head with a knobkierie, the dagga *evaporates* and thus no injury occurs').

Comparison of interaction across age groups

Age group I (7-10 year olds) focused on the toys, and played a lot with the balls, dolls and bricks. In Group II (11-14 year olds) the boys played with the balls, but ignored the other toys. In Group III (15-17 year olds) the girls played a bit with the toys which the boys largely ignored.

Another significant factor was the willingness to venture. In Group I the boys showed some willingness to mix and explore. This seemed to intensify in Group II, with more *daring* and competitive behaviour, and intensified even further in Group III, the boys of which openly explored and easily manipulated their environment.

The children's awareness of an audience seemed fairly constant across the groups. The only change which possibly occurred was that the older girls seemed more aware of this audience than the younger ones.

Sharing behaviour, almost entirely absent in the younger boys, could not really be observed in the older groups, as the toys were not really used. The younger boys seemed to become bored and frustrated. This tendency was not observed in the older boys.

The behaviour of the three age groups seemed to differ most significantly in the mixed-sex sessions. The younger children (7-10 years old) primarily maintained quite distinct separate-sex groups.

In the 11-14 year olds, the girls' groups and the boys' groups mixed more freely, with the more extrovert among the boys and girls interacting extensively.

In the older age group (15-17 years old), boys and girls seemed united in a single group, and the effect of this mixing seemed to be to make the views they expressed (in terms of drugging) more extreme. This possibly involved some adolescent posturing, especially on the part of the boys.

Knowledge of substances of abuse seemed to increase across age groups, with similar trends evident among the boys and girls, *although overall the boys seemed to have experimented with a wider variety of substances.* The older group seemed to know more brand names and popular names for those substances than did the younger group.

Rape was mentioned by boys and girls in the youngest and oldest groups as a phenomenon associated with substance abuse.

Discussion

The fact that children are being exposed to a wide variety of chemical substances, which are relatively available, seems beyond dispute. Many children seem to need to venture no further than their homes to gain access to these substances. Their knowledge of a number of brand names, cigarettes and alcoholic beverages seems evidence of a few particularly effective advertising campaigns.

In certain respects, it could be suggested that girls may be less susceptible to pressures to use psycho-active substances than are boys. They seemed to self-monitor their behaviour more, to be aware of the presence of adults, and to need to behave *appropriately*. Leaders who emerged in the groups also seemed to have a containing effect. The girls also seemed to have some role models (for example, teachers) who were important to them and could provide some positive guidelines to them in dealing with developmental tasks.

Some more negative implications could be linked to the above. Feelings of powerlessness among the girls may possibly be indicated. It could be tentatively suggested that their need for a conservative approach indicates a perception among girls that their roles could be as victims, for example, of rape. Their fascination with *pregnancy* could be investigated further, *possibly* as a need on their part to gain *security. This could possibly expose these girls to sexually risky behaviour.*

The boys seemed more open to influences which could promote the use of psycho-active substances. No positive leaders emerged in the boys' groups. Group interaction was less organized than the group interaction of the girls. A high level of competitiveness was evident.

Finally it may be said that girls across all age groups demonstrated some interesting behaviour in acting out scenes from the movie *Sarafina*. A favourite scene was when Whoopi Goldberg said, 'My children, you are so beautiful, God must be very happy when he looks down and sees you'. *The fact that black children in this country have largely lacked role models could explain their having memorized large segments of this movie. Furthermore, it could suggest a powerful means of intervention regarding preventative education, if self-esteem issues were addressed through affirming the use of appropriate role models.*

Case studies

Case study 1

E.T. Mmbara
Student social worker

Introduction

Tsepo, a 14 year-old male youth, was admitted to the Streetwise Soweto shelter in Dube on 16/10/1992, after having run away from home to the streets of Hillbrow on 4/6/1992. In August 1992 he started visiting the Streetwise Johannesburg shelter in Hillbrow, and he was transferred to the Soweto shelter in October 1992.

Background information

Tsepo, the fourth child of a family of six children, five boys and one girl, was the youngest. Both biological parents were alive and living with the children. Tsepo and his five siblings lived under extremely poor conditions. Both parents were unemployed and his eldest brother was in prison at the time, having been arrested for theft, probably committed to assist the family. There was indiscriminate abuse of alcohol in the family. Both parents, and two elder brothers, abused alcohol. The house was filthy, with sparse old furniture, and the entire family of eight lived in a two-roomed house. Tsepo had fairly good relationships with his mother and siblings, but resented his father for not supporting them and for spending most of his time drinking. As four of the boys were school drop-outs, only the youngest boy and girl were still at school, battling with minimum school facilities. Tsepo dropped out of school in 1992, when he was 12 years old and in Standard 2.

Problem and drinking history

Tsepo stated that he dropped out of school and took to the streets of the suburb because his home conditions were so bad. Most of the time his family were without food or warm clothes. Nights in winter were a nightmare: there were not enough blankets and no coal to keep a fire going. The father coming back in the middle of the night, drunk and abusive, was the last straw. At school Tsepo was the laughing stock, had no uniform or clean clothes, and sometimes he had to steal other children's books to have something to write on. Nobody seemed to care, neither his parents nor the teachers.

Some of the teachers ridiculed him for not having clean clothes, books and a uniform. None of them, he stated, paid a house visit to see the conditions under which he lived. Ultimately, when everything seemed hopeless, in June 1992, he took to the streets. There he started to sniff glue, because, according to him, it made him feel okay. He stated that he forgot his family with all their suffering, forgot his hunger and cold; he also stated that he hated the taste and smell of the glue. He had to beg or wash taxis for money to buy the glue which he had to have, especially on days when there was no food in dustbins and the people were not generous.

Tsepo stated further that what hurt him most out there in the streets were the hurtful and abusive attitudes of the community, who despised street children for being in the streets, instead of trying to understand their suffering. He asked me to pass his sincere thanks to the press, to anyone and everyone who had shown kindness to those in the streets. It went a long way towards easing their continuous suffering. He called on all the gods to give organizations like Streetwise, and all other organizations that care for the poor and destitute, especially children, lots of strength.

Progress at Streetwise shelter

To date, Tsepo has been at the Dube shelter for approximately two years. Kind and sensitive, he is said by one of his former school teachers to have been a nice boy who respected his elders. The shelter staff has re-united him with his family, who were overjoyed to know where he was, although they had never made any attempts to find him. They would like the shelter to continue taking care of him while they will support him emotionally. Tsepo is currently attending one of the local schools and is in Standard 4. He is progressing very well, and the teachers are pleased with his behaviour and attitude towards other children. At the shelter he is co-operative and respectful to the house mothers. However, he refuses to visit his home, until his father takes treatment for his alcohol problem.

To date, his brother is still in prison. His two younger siblings are now at school. Requests have been made to NICRO and SANCA, Soweto to assist with the alcoholic father and imprisoned brother.

The manager of Streetwise Soweto has tried to assist in finding employment for both parents, but as both are unskilled with little education, no employment has been found.

The social worker has requested Operation Hunger to supply the family with food parcels immediately.

Conclusion

Further intervention must include

- encouraging Tsepo to visit his home and make peace with his father,
- encourarging him to continue with his schooling, and
- assisting him to change his attitude towards the community, as he feels that blacks are uncaring people.

Case study 2

P. Tshabalala
Manager, Soweto Day Care Centre

Introduction

Vusi, a 16 year-old primary school pupil at one of the local schools, was referred to NICRO for an alternative sentence after he had been caught in possession of dagga and two mandrax tablets, following his assault on a local youth.

Background information

Vusi was the youngest of a family of four children. His three siblings were a boy and two girls. His father died after a long illness of tuberculosis and his mother was a pensioner. The eldest boy was married and working. One of the two girls was working and the other was unemployed.

Drugging history

Vusi's father drank heavily until his death. His mother did not drink at all. His eldest brother and younger sister both drank. Vusi started experimenting with dagga at the age of 13 years, and at 14 years the drugging began to interfere with his schooling. At 15 years he proceeded to white pipes (a mixture of dagga and mandrax). He admitted that he was drugging every day, and had to steal from his house and neighbours to support his habit. He stated that obtaining these drugs was the easiest thing, as they were readily available in the townships.

Progress in rehabilitation

The magistrate, after he had declared Vusi a *user*, and not a dealer, sentenced him to alternative service, as he decided that the assault was a result of Vusi's being under the influence of drugs. He was referred to PEDRO (Project for the Education of Drug-related Offenders), which expects offenders to attend classes weekly and answer questionnaires related to their drugging habits. Vusi attended regularly and, according to completed questionnaires, showed insight into his problem and a willingness to change his lifestyle.

Conclusion

Vusi is now training as a carpenter with the Department of Manpower. He still attends PEDRO on a weekly basis. NICRO will keep in touch with Vusi until the three phases of PEDRO have been completed, namely

- the introduction session to discuss the extent of the drugging,
- the group therapy sessions, and
- the follow-up sessions.

Case study 3

P. Tshabalala
Manager, Soweto Day Care Centre

Introduction

Mandla, a 17 year-old male, was first admitted to the SANCA Soweto Day Care Centre on 15/1/1990, after he had been referred to us by his maternal granny, with whom he was living. He was referred to the centre because he was sniffing glue and had dropped out of school in June 1989.

Background information

> Mandla was born out of wedlock and had a younger biological sister who was still attending school. He was living with his granny at the time and his mother was living in another township with a boyfriend (a man who was not Mandla's father) and had two other daughters by different men. A four-roomed house was home to Mandla, granny, two uncles and three aunts. Two of the aunts had

two children each and were unmarried, adding up to 12 children including Mandla's sister.

Mandla vaguely remembered his biological father. It appeared that Mandla preferred to have very little to do with his father, as he quickly changed the subject when he was discussed. The subject of his mother interested him, and on this subject he could go on and on, questioning why his mother did not live with his sister and himself, as if he expected answers from me. He was very close to his sister who was four years younger than he, and was actually very protective towards her.

Mandla dropped out of school in Standard 2. He stated that he never had much interest in learning anything and hated the teacher, who was, incidentally, male. Mandla had a very warm and close relationship with his granny and said his uncles, together with their children, were okay. Mandla came to the Centre fairly clean and looked reasonably well fed. They all lived off the granny's pension money, and it had become Mandla's monthly duty to escort her to collect the pension from the local administrator's office. The Centre granted him permission to continue to accompany his granny, as the aunt and uncles were not interested in taking over that task, despite requests to this effect by the Centre manager.

Drugging history

According to the granny, Mandla started sniffing glue in 1989 and, according to Mandla, in 1987 at the age of ten years. He was introduced to glue by a boy very much older than himself, but a very close friend who had dropped out of school a long time ago.

Mandla explained that his friend always seemed to have money to buy more glue from their local shop. He himself had never spent his money on glue. Mandla stated that he loved the feeling he got from glue: he mentioned that he could do anything he wanted to, like being arrogant to his elders, including his family, and that he felt equal to his friend and did not notice the age difference, which, according to his granny, was quite significant. He stated that in the beginning he did not like the choking effect of glue and sometimes hid from his friend who came looking for him, and did not use much of the glue.

He stated that after a few months he looked forward to it. He started getting reckless and destructive in class, and was often thrown out or reported to the school head. He said that, at that stage, he thought the class teacher had something against him, and the more he sniffed glue, the more he hated school. In the middle of 1988, he started playing truant but nobody noticed, least of all his mother who did not visit them often. He mentioned that he did not mind if the family discovered that he was sniffing, as this would 'serve them right' for not allowing him and his sister to live with his mother.

Progress in treatment at the Centre

Mandla did extremely well at the Centre. There was no need for medication as he showed no signs of withdrawal. He was having a problem with his drugging friend, as the friend resented Mandla's refusal to drug with him. Mandla showed leadership qualities, with the result that the teacher relied on him to supervise others during cleaning time. He relapsed twice during his stay at the Centre, information which was received from his granny and not volunteered by him. When he later spoke about his relapse, he mentioned that his friend had forced him to sniff with a group of other boys.

Mandla's granny was asked by the Centre staff to intervene and report the matter to the friend's mother, which she did.

Mandla was also an ardent lover of gardening and started a vegetable garden behind their tiny four-roomed house, and this kept him off the streets.

In 1991 he received a first prize in a colouring-in competition for informal schools in Soweto, and has a beautiful travelling bag to prove his success.

Conclusion

It is my opinion that Mandla's case highlights two important issues about SANCA Soweto Day Care Centre, namely that

- if there is a prompt referral of problem children, the prognosis is almost always very good, and
- the Centre serves as an intervention half-way house to stop would-be street children from leaving home and taking to the suburban streets, thereby increasing the ever-rising numbers of children on the streets.

If Mandla was not brought to the Centre by his granny at the suggestion of a local school teacher, he might have been a different person today, probably a delinquent or criminal in the township streets.

Mandla who is a talented artist, a skill recognized by Margaret, a volunteer *art therapist* at the Centre, is now attending Saturday art classes at FUNDA Centre.

Because of his age and early school drop-out history, he can unfortunately not return to school, but we all hope that he will succeed as an artist.

Summary

In the course of the fairly open-ended study of a group of historically disadvantaged young people between the ages of seven and 17 years, resident in a major metropolitan centre, the following insights regarding alcohol, tobacco and other drug-related behaviour and attitudes emerged:

- Attitudinally and in terms of the theoretical framework of the present study, the relevant young people were in various ways risk-prone with regard to the development of alcohol-drug-related problems. Indeed, it is clear that they were *acquainted* with a variety of alcoholic beverages and various other drugs. Although the belief appeared firmly entrenched that *alcohol, tobacco and other drug use has potential for adverse consequences* (such as sexual abuse, particularly rape, violence and crime), it is clear that it did *not necessarily deter them from usage*. Indeed, a fair degree of *tolerance* towards the use of alcohol, tobacco and other drugs surfaced and seems to have become more marked as the youngsters grew older. *Positive associations* regarding the use of these substances also emerged. Examples in this respect are the belief that cannabis/dagga helps a person to lose weight, makes a person sleepy or strong, stimulates extra-sensory experiences and *protects* the user against harm.

- *Gender differences* with regard to alcohol, tobacco and other drug-related attitudes and beliefs were apparent. Indeed, boys rather than girls seem to have been *open* or tolerant to engaging in alcohol/drug use. These differences appear to be associated with certain psychological factors. For example, boys, in contrast to girls, seem to have been fairly prepared to explore, to experiment (also with a particular substance e.g. cigarettes), and to have done so rather *vigorously*, without carefully planning or evaluating the *appropriateness* of their actions. Boys tended towards competitiveness. In a group dynamic, boys seem to have been disinclined towards organizing themselves into fairly stable groups under particular leadership. In the case of girls, the opposite applied. Most importantly, girls seem to have been more concerned than boys about the *appropriateness* of their behaviour, *fitting* in and submitting to *outside* control regarding their personal behaviour. In this respect, note should be taken of certain tentative indications of a sense of 'powerlessness' among girls, of their being 'victims' with regard to the environmental circumstances they find themselves in.

- Both the observational sessions, group discussions and case studies showed that youngsters were subjected to various forms of *environmental 'pressure'* with regard to alcohol/drug use: they were *exposed* to, and *peer-pressured* into, them. *Easy access* to the various substances and *limited discrimination* against usage seem to have been the order of the day. The case studies, in particular, indicated the importance of *family circumstances* in the development of alcohol, tobacco and other drug-related problems. Indeed, the case studies support overseas evidence (Fossey, 1994) that risk-prone alcohol-drug-related parental behaviour, tolerant parental attitudes towards alcohol-drug use and, more generally, low levels of family *control, support* and *intactness* (parents mostly absent) are most conducive to the development of alcohol/drug-related problems among youngsters. A need to *cope with life by escaping* into alcohol/drug use seems to have been particularly important for initiating/ maintaining drinking, smoking and drug-taking habits.

Section 3

Survey findings

Level of alcohol, tobacco or other drug intake[5]

A substantial proportion (42,5 per cent) of the respondents in the 1994 study on alcohol, tobacco and other drug intake reported that they had had a proper drink of alcohol some time in their lives. (This proportion is substantially lower than the 53,2 per cent in a 1990 study by Flisher *et al.* (1993), among a somewhat similar age group, but within a more restricted geographical area and including historically disadvantaged as well as advantaged young people (secondary school children in the Cape Peninsula).) The 42,5 per cent was also substantially lower than the figure of a 1989 national study among white Standard 8 and 10 pupils, in which 54,9 per cent admitted the use of alcohol at the time of the study (Department of Education and Culture, 1990).

By far the majority (79,9 per cent) of the young people in the 1994 study who said that they had used alcohol at some time in their lives, admitted current drinking (that is, had consumed some form of alcoholic beverage in the 12 months preceding the survey). In fact, a substantial proportion (34,0 per cent) in the total sample reported current drinking. (The proportion of current drinkers was somewhat higher than in the 1990 Cape Peninsula study (26,9 per cent) (Flisher *et al.*, 1993), possibly because in the latter case the emphasis was on

---

[5] It is important to note that in this and subsequent sections, comparison of the present survey's findings with those in related local and overseas studies will be directed at identifying *trends* and, indeed, placing the present study within a wider context, rather than identifying absolute differences or absolute similarities.

recent use or, for that matter, *having used alcohol at least once in the past seven days.*)

Current drinking in the 1994 study was somewhat more common in relatively urbanized areas (areas outside the former TBVC and self-governing states) and was more marked among males than females, particularly within the rural areas. (That is, 40,4 per cent of the males and 32,4 per cent of the females resident in areas other than the former self-governing states and TBVC states admitted current alcohol use; the comparative proportions for the latter areas were 39,2 per cent and 23,0 per cent (Appendix A, Table 5).) The proportions of current drinkers were, however, markedly lower than those in two basically comparable 1990 national surveys largely among adults (Appendix A, Table 6) (Rocha-Silva, 1992). However, the gender differences in the adult groups are repeated in the younger sector.

Detailed demographic analyses[6] show that:

- The *proportion of drinkers increased with age* (this trend has manifested consistently in a number of South African studies among somewhat similar age groups but in otherwise more restricted samples (Flisher *et al.*, 1993);
- Drinkers were found particularly in the *18-21 year age group*, with *males* being most prevalent, especially those indicating that in the 12 months preceding the survey they *had taken part in festivities* or attended gatherings (such as birthday parties, weddings and the unveiling of tombstones) and who resided in *metropolitan centres or urbanized towns*;

---

[6] A CHAID computer programme was used (Du Toit, *et al.*, 1984). The reader is referred to the project leader, Lee Rocha-Silva, for details regarding the demographic analyses.

- Female drinkers in the age group 18-21 years were especially those who reported that they had attended *festivities*/gatherings (such as birthday parties, weddings, and the unveiling of tombstones) in the 12 months before the survey;
- The younger age group, *14-17 years*, showed a similar trend to the older group, namely that *drinkers* included particularly those who had attended *festivities*/gatherings, but *had never attended church* in the 12 months preceding the survey;
- In the youngest age group, *10-13 years*, drinkers particularly constituted those who said that they had attended some or other *traditional ceremony* (*umsebenzi waba phantsi*/*mosebetsi waba dimo*) in the 12 months preceding the survey.

Regarding the *type of alcoholic beverage* (Appendix A, Table 7) consumed by current drinkers, *ordinary beer* seems to have been the *most commonly used* alcoholic beverage *among males generally*, while *distilled spirits* seems to have been the *second* and *wine the third most popular alcoholic beverage* among these drinkers (73,9 per cent of the male drinkers in the urbanized areas and 76,5 per cent in the rural areas consumed ordinary beer; the comparative proportions for distilled spirits were 42,5 per cent and 43,9 per cent, and for wine 35,3 per cent and 41,8 per cent). Substantial proportions of the male drinkers imbibed cider and home-made liquor, although cider was more popular than home-made liquor in the urbanized areas than in the rural areas (32,7 per cent of the male drinkers in the urbanized areas consumed cider and 28,1 per cent home-made liquor; the comparative proportions in the rural areas were 34,7 per cent and 37,8 per cent). *Female drinkers* in the *urbanized areas* seem to manifest a *fairly homogeneous pattern* in terms of beverage preferences, except with regard to home-made liquor and distilled spirits (45,8 per cent consumed ordinary beer, 44,5 per cent wine and 42,6 per cent cider).

In the *rural areas, wine and cider were by far the most popular* among *female* drinkers. The *popularity of wine among young female drinkers* generally *resembled the situation among their adult counterparts,* particularly with regard to the rural areas (Appendix A, Table 8) (Rocha-Silva, 1992). What is somewhat disturbing, though, is that the *young male drinkers* in the 1994 study seem to *have preferred distilled spirits to home-made liquor.*

Concerning statistically significant demographic differentiations with regard to type of alcoholic beverage used by current drinkers, the analyses show that:

- Apart from the fact that *drinkers of ordinary beer* were, in *particular, males,* they were *14 years or older* rather than younger. *Female beer drinkers* were especially those who were *married or had a boyfriend.* (The female beer drinker who was not married and did not have a boyfriend was mostly resident in informal settlements);

- *Drinkers of distilled spirits* were also mostly *male,* in the older (*14 years and older*) rather than younger age group, and mostly *had children;*

- *Female drinkers of distilled spirits* were once again particularly those who were *married or had a boyfriend;*

- Regarding *wine drinking,* age and gender do not seem to have been as relevant as in the case of the consumption of ordinary beer and distilled spirits. It seems to have been particularly common among young people who said that they had attended *festivities* or gatherings in the 12 months before the survey. Only among the wine drinkers who attended festivities did the previously noted age and gender differentiations apply (older rather than younger respondents were included among the relevant group, and *females* rather than males drank wine);

- *Cider drinkers*, in particular, were found in the oldest age group (*18-21 years*) in the survey, although the middle group (*14-17 years*) were also fairly well represented. Cider drinkers in the *18-21 years* age group were mostly those who reported being *married or having a boy or girlfriend* and, among these, especially those who said that they *had attended traditional ceremonies* in the 12 months preceding the study. Those drinking cider in the *14-17 years* age group particularly said that they had attended *festivities* or gatherings (such as birthdays, weddings and the unveiling of tombstones) in the year before the survey. Cider drinkers, particulary in the youngest age group (*10-13 years*), included those who had attended *traditional ceremonies*;
- *Home-made liquor* seems to have been especially popular among current drinkers who reported having attended *traditional ceremonies* in the year preceding the survey, and among these, those resident in *informal settlements* or the former *self-governing and TBVC states* were particularly well represented. What should also be noted is that those drinkers of home-made liquor, who said that they had never attended traditional ceremonies in the past year, included specifically those who reported they had not attended *festivities* or gatherings (such as birthday parties, weddings and the unveiling of tombstones) in the relevant period.

With regard to the frequency with which various alcoholic beverages were consumed by current drinkers (Appendix A, Table 9), it seems that no matter what was consumed, the young people concerned generally reported *drinking less frequently than once a week, except* with regard to the use of *ordinary beer and cider by males* in the rural areas (*former self-governing and TBVC states*). Indeed, in terms of frequency of alcohol intake, young people in the *urbanized areas generally manifested* a fairly *conservative picture compared to their adult counterparts* (Appendix A, Table 10) in the 1990 national study referred to (Rocha-Silva, 1992). This especially applies to the use of ordinary beer. With regard to *distilled spirits*, the proportions who drank fairly regularly (at least once a week) among the younger group in urbanized areas seem, to some extent, to approximate the comparative proportions in the adult group. With regard to the *rural areas* (former self-governing and TBVC states) *regular drinking* generally seems to have been *more popular among the young people in the 1994 study than among the adults* in the earlier 1990 study. (It is also important to note that in the 1989 national study (Department of Education and Culture, 1990) among white Standard 8 and 10 pupils, 22,4 per cent of the current users of alcohol admitted taking it at least once a week, which resulted in a somewhat lower proportion than was generally the case in the 1994 study.)

Detailed demographic analyses of the responses show that:

- The fairly *regular use* (at least once a week) of *ordinary beer* was particularly common among the oldest age group (*18-21 years*) and especially among those who reported *not ever having attended church* in the 12 months before the study;

- *Regular use of cider* was especially prevalent among current cider drinkers who *had children*. Those with a less regular intake of this beverage, in particular, did not have children, were single and female;

- *Regular drinking of home-made liquor* was more common among the older (*18-21 years*) than younger age groups;

- Regarding *wine drinking, regular consumption* was especially prevalent among the older age group (*14-21 years*).

In respect of *volume of alcohol intake*,[7] note should be taken that, in contrast to their adult counterparts (Appendix A, Table 12), by far the majority of the *young current drinkers* in the 1994 study reported a comparatively low *total annual volume of consumption*, irrespective of the particular beverage concerned (Appendix A, Table 11). In fact, by contrast with the relevant adults, the young drinkers mostly reported less than 26 litres per annum per alcoholic beverage. The same applies to absolute alcohol (AA)[8] intake per annum in urban areas (Appendix A, Tables 13 and 14). What is disturbing, though, is that the volume of absolute alcohol intake of *noteworthy proportions* of, in particular, *male drinkers* may be described as *heavy* in terms of overseas standards (Fossey, 1994:31), i.e. they imbibe on average at least 7 cl AA[9] per day, or on average 49 cl AA per week. Although comparative South African figures are not available, the 1990 Cape

---

[7] In terms of the KAT formula (Rocha-Silva, 1987), a drinker's total annual consumption of a particular beverage is calculated by multiplying his usual as well as maximum quantity of consumption per occasion by the frequency with which it is consumed per year. The following calculations are made:

$(\mathrm{FUi}-\mathrm{FMi})\ \mathrm{VUi} + \mathrm{FMi}\ (\mathrm{VMi})$ with

FUi = Usual frequency with which a particular beverage is consumed over a period of 12 months

VUi = The quantity of a particular beverage that is usually consumed per occasion.

VMi = The maximum quantity of a particular beverage that has been consumed per occasion.

FMi = The frequency with which above maximum quantity has been consumed over the 12 months of concern.

[8] Total annual absolute alcohol intake is calculated by expressing the total annual quantity (litre) of, respectively, ordinary beer, cider, wine, sorghum beer and distilled spirits that a drinker consumes in terms of absolute alcohol. It is assumed that ordinary beer contains 6,0 per cent absolute alcohol, cider 5,0 per cent, wine 12,0 per cent, sorghum beer 3,0 per cent and distilled spirits 43,0 per cent (Cooper, Schwar & Smith, 1979; Personal communication with representatives of the Department of Agriculture, 1994 and the Council for Scientific and Industrial Research, 1994).

[9] 7 cl AA = 6,5 tots of distilled spirits, or 4,7 glasses of wine, or 3,4 small bottles/cans of ordinary beer, or 2,3 litres of sorghum beer, or 4,1 cans/bottles (340 ml) of cider.

Peninsula study (Flisher *et al.*, 1993) among secondary school pupils supports the present finding of male predominance with regard to the intake of comparatively large amounts of alcohol.

Various demographic factors differentiated statistically, significantly[10] among drinkers with regard to volume of consumption:

- In respect of the *total annual volume of wine intake, female* drinkers generally *imbibed more* than their male counterparts; wine drinkers in the older age group (*14-21 years*), and especially those who *had children*, as well as those who *had never attended church* in the 12 months preceding the study, particularly reported a comparatively large total annual amount of wine consumption;
- With regard to *total annual beer intake, males* rather than females tended towards *larger amounts of intake*; *volume* of intake also generally *increased with age*; *drinkers who had children* generally reported a *higher intake* than those without children; larger amounts of intake were also generally reported by (a) those who had *never attended church than those who had* and (b) those who had attended *festivities* (such as birthday parties, weddings, the unveiling of tombstones, etc.) than those who had not in the 12 months before the survey;
- With regard to *total annual intake of distilled spirits*, users of this beverage who were resident in *areas other than informal settlements* generally reported *larger amounts* than those in informal settlements; the *volume of intake* of those who *had never*

---

[10] A multiway ANOVA computer programme (Fox, 1984) was used because of the continuous nature of the dependent vairable.

attended church in the 12 months preceding the study was also generally *larger* than the volume of intake of those who had;

- In respect of the *total annual volume of intake with regard to cider*, comparatively *higher levels of intake* were particularly prevalent among male drinkers, those who *had children*, and those who *had never attended church* in the 12 months preceding the study;
- In respect of the *total absolute alcohol intake*, comparatively *larger amounts* were generally reported by drinkers *resident in areas other than informal settlements, male drinkers*, drinkers who were *married or had a boy/girlfriend*, drinkers who *had children* and those who *had never attended church* in the 12 months before the survey; the *level of intake* also *progressively increased with age*.

Level of intake with regard to substances other than alcohol

Regarding the use of substances other than alcohol in the *12 months prior to the present study*, the *most popular* substances were, in order of popularity, *over-the-counter pain-relievers*, other *over-the-counter medicine* (such as Lennon's products, allergy and cough medicine), *cigarettes/tobacco*, and, to a lesser extent, *non-prescriptive sedatives, non-prescriptive tranquilizers* and *non-prescriptive stimulants* (Appendix A, Table 15). Between 20 and 40 respondents admitted using dagga, *non-prescriptive narcotics* (other than heroin), *steroids, mandrax, solvents* and *LSD* in the 12 months prior to this study. The current use of cocaine and heroin was reported by 11 and 13 respondents, respectively. The proportion who reported *use of the relevant substances by neighbours* was generally *larger* than the proportion reporting that they themselves had at some time in their life used the substances concerned (except with regard to over-the-counter substances) or who admitted current use (Appendix A, Table 16).

Substantially smaller proportions of the young people in the 1994 national study, than in the 1990 national survey largely among adults reported currently using cigarettes/tobacco, dagga, LSD, cocaine, heroin and non-prescriptive narcotics (other than heroin) (Appendix A, Tables 15 and 17). Moreover, the prevalence of current use of over-the-counter pain-relievers and other over-the-counter medicine among the young people in the 1994 study seems generally to resemble that among the largely adult sample of the 1990 study. The use of substances such as sedatives, tranquilizers and stimulants seems to be somewhat more common among the young people than among their elders.

Moreover, a comparison of the findings of the earlier more restricted Cape Peninsula study (Flisher *et al.*, 1993) among secondary school pupils with those of the 1994 national survey suggests to some extent the possibility that particular substances may be more common in certain regions than in the country as a whole:

- A substantially smaller proportion of the total sample in the present study (12,9 per cent) than that in the Cape Peninsula study (18,1 per cent) admitted to having smoked cigarettes/tobacco;
- A substantially smaller proportion of the total sample in the present study (3,8 per cent) than that in the Cape Peninsula study (7,5 per cent) admitted to having used dagga;
- A somewhat smaller proportion in the present study (7,4 per cent) than that in the Cape Peninsula study (10,9 per cent) said that they had sniffed glue, petrol, etc. at some time in their lives.

However, more or less similar proportions in the present study (2,0 per cent) and in the Cape Peninsula study (1,6 per cent) reported that they had at some time smoked a white pipe. On the other hand, reported lifetime use of substances such as mandrax, cocaine, LSD and non-prescriptive narcotics (other than heroin) was more prevalent in the 1994 national study (Appendix A, Table 16) than in the Cape Peninsula study (Flisher *et al.*, 1993:484).

With reference to the *frequency* with which current users used substances other than alcohol, the survey indicates that, as was the case in the earlier adult survey (Rocha-Silva, 1992) (Appendix A, Table 19), *cigarettes/tobacco* and, to some extent, dagga were mostly used *at least once a week* (Appendix A, Table 18). The opposite applies to the other substances of concern.

In terms of *quantity of consumption*, the focus in the present survey (1994) was on *cigarettes/tobacco*. (With regard to substances other than alcohol and cigarettes/tobacco, quantity of intake was not ascertained by reason of too wide a variation in the units of consumption.) By far the *majority* of the current smokers (85,7 per cent of the males and 77,2 per cent of the females in the urbanized areas; in the rural areas the comparative proportions were 96,7 per cent and 60,0 per cent) used two or more cigarettes per day (Appendix A, Table 20).

Analyses of the demographic characteristics of users of substances other than alcohol showed that:

- The *proportion of smokers* progressively *increased with age*, with *males* consistently overrepresented in the various age groups;
- Smokers, whether male or female, but particularly those in the older age groups, also seem to have been especially those who *had never attended church and/or had attended festivities* or

gatherings, such as birthday parties, weddings and the unveiling of tombstones, and *had children* (the latter particularly applied to male drinkers in the 18-21 years age group);

- *Frequent smoking* (at least once a week) was especially common among the oldest age group (*18-21 years*) among whom *males* were particularly prevalent (Flisher *et al.*, 1993 established a similar trend);
- Those smokers who smoked *higher quantities* (five cigarettes or more per day) were, in particular, people who *had children*;
- Young people who said that they had used over-the-counter *pain-relievers in the 12 months prior to the study* were especially resident in *informal settlements and urbanized towns*; while those who used these substances at least once a week were from *urbanized towns* rather than informal settlements;
- Respondents who reported use of *over-the-counter medicine* other than pain-relievers had *attended* rather than not attended *church* in the 12 months before the study, and were particularly those resident in *urbanized towns* rather than the other centres concerned, while those among them who *used* these substances frequently (*at least once a week*) were mostly people who had *attended festivities* or gatherings, such as birthday parties, weddings and the unveiling of tombstones.

First attempt at using alcohol, tobacco or other drugs

The reported *age of onset* (Appendix A, Table 21) with regard to the use of alcohol, cigarettes/tobacco and dagga was mostly from *14* *years and older*. The age of onset tended to be *younger in the case of solvents*. However, among those who reported that they *smoked* at some time in their lives, the single largest proportion said that they had their *first try at cigarettes/tobacco before they had a try at alcohol*, although substantial proportions reported that it was the other way round. The relevant *females* in the *urbanized areas* tended to state that their *first experience* was with *alcohol rather than cigarettes/tobacco*. In this respect it should also be noted that there is a statistically significant correlation (at the 0,01 per cent level of significance) between current smokers and drinkers, i.e. current smokers tend to be current drinkers as well.

With regard to alcohol, cigarettes/tobacco and solvents, but especially in the case of the latter, the single largest proportions of the relevant respondents stated that they got their *first drink/cigarette/tobacco from friends* (Appendix A, Table 21). However, substantial proportions said that they obtained these substances themselves. Detailed demographic analyses showed that those who obtained their *first drink from friends* were in the *older* rather than younger age group. The youngest age group (*10-13 years*) stated mostly that they obtained their *first drink from relatives*. The age group, *18-21* years, rather than the younger ones, stated that *they got their first drink themselves*.

The proportions who said that their *first try at alcohol* was *'nice'* were larger than those who said it was not, *especially* among those residing in *metropolitan centres* or the rural areas (former *self-governing and TBVC states*). The *opposite applied to cigarettes/tobacco*, especially among the younger age groups (the oldest age group (*18-21* years) and *males* in the *rural areas* (Appendix A, Table 21) were exceptions). The reported *experiences after the first try at solvents* were also *generally negative,* with the exception of female respondents in the urbanized areas. The older age group (*18 years and older*) and especially *males* were over represented among those who *wanted to drink/smoke again* after their first try. In the case of drinking, the latter-mentioned comprised those who were resident in *urbanized towns* and in the *rural areas*. In this respect, noteworthy proportions, particularly among males and especially in rural areas, responded 'Yes' to the question: 'Do you think you may use alcohol/cigarettes/tobacco when you get older?' (With regard to alcohol, 10,6 per cent of the males in urban areas and 19,2 per cent in rural areas, as well as 2,8 per cent of the females in urban areas replied 'Yes' to the relevant question; for cigarettes/tobacco the respective percentages were 13,2, 17,6 and 2,9.)

With regard to the *reasons* the relevant respondents gave for their *first attempt* at alcohol, cigarettes/tobacco and solvents, the single largest proportions generally stated that they did it 'to see what it was like, because a friend insisted', and 'I thought it would be fun' (Appendix A, Table 21). It should also be noted that demographic analyses showed that with regard to *drinking*:

- *Experimentation* ('to see what it was like') was particularly important to the *younger age groups,* 17 years and younger, and especially to those resident in the *metropolitan centres and rural areas* (former self-governing and TBVC states) who reported that they had *attended church* in the 12 months prior to the present study. The *latter particularly applied to the very young ones* (*10-13 years*);

- Within the age group *17 years and younger,* those resident in *informal settlements and urbanized towns* regarded *fun* as *less important* than those in the other areas;

- *Fun* was more important to the *18-21 year olds* than to the younger age groups.

With regard to *smoking*, respondents in the *informal settlements and rural areas* emphasized the *pressure of friends* to a greater extent than the relevant respondents in the other areas.

Reasons for using or abstaining from alcohol, tobacco or other drugs

Of particular note is that young people in the present study who stated that they *had never used alcohol or smoked cigarettes/tobacco* in their lives, pointed out that they had abstained because they felt it would be *bad* for them, although their *youth was also fairly frequently noted as a reason for not drinking* (Appendix A, Table 22). In this respect, it should be noted that by far the *majority of the respondents*, whether they had or had not used alcohol or cigarettes/tobacco at some time in their lives, *answered the question*: 'Do you think you may drink/smoke when you get older?', negatively (74,4 per cent in the case of alcohol and 83,3 per cent in the case of smoking).

It should also be noted that those who said that their *main reasons for not drinking* were that *it was a bad habit, it destroyed the future ... etc.*, and *was not their lifestyle*, were particularly in the older, *18-21 years*, age group and *had attended church* in the 12 months prior to the study. Respondents who gave as their *main reason for not smoking*, that 'it harms lungs, not good for my health, don't want to get TB/cancer/asthma, it is bad for me, it is a bad habit', were especially those who had attended *festivities*/gatherings such as birthday parties, weddings and the unveiling of tombstones in the 12 months prior to the study and who were resident in *informal* *settlements*. Major proportions (between 90,9 per cent and 94,4 per cent) gave as their reason for not smoking 'I do not want to smoke' (Appendix A, Table 22).

Moreover, with regard to the other reasons that were fairly frequently given for not drinking or smoking cigarettes/tobacco, the following should be noted:

- The young people who said that they *did not drink because their friends were against it* were especially those resident in *metropolitan centres*, had attended *festivities* in the 12 months before the study, and were *female*. Those respondents who gave this reason for not drinking and who were *not living in metropolitan areas* were mostly *church-goers*;
- Respondents who *did not smoke* because they 'disliked the taste' of cigarettes/tobacco were particularly people who *had attended festivities* in the 12 months prior to this study. Those who gave as reason the fact that 'it is not possible to stop the habit of smoking', were especially resident in *metropolitan centres*, *males* and had attended *festivities* in the 12 months before the study. The 'disapproval of parents/guardians/spouse', was a particularly popular reason for not smoking among young people in *metropolitan centres* and *informal settlements*. *'Friends are against smoking' was a frequently mentioned reason among metropolitan residents* especially, particularly those in the younger age groups (*17 years and younger*).

With regard to reasons for *drinking*, *mood-changing* ('coming nice') (particularly among *rural* respondents), *enjoyment* ('because I enjoy it') and *experimentation* ('to find out what it was like') seemed to be particularly popular (Appendix A, Table 23). In this respect it should be noted that *fun/enjoyment* was also particularly prevalent among the responses to the open question concerning *main reason for drinking*, and particularly so among the older age groups (*14 years and older*). Those in the younger age group (*10-13 years*) who regarded fun/enjoyment as the main reason for drinking, were particularly *metropolitan residents*. It should also be noted that the emphasis the respondents in this study placed on enjoyment and mood-changing resembled that of their adult counterparts (Appendix A, Table 24a and 24b).

Substantial to major proportions also responded positively to statements such as: 'I like the taste, to give myself courage/ confidence, so as not to be the odd one out, because my friends drink, so that my friends won't think I am scared' (Appendix A, Table 23). That drinking was associated with *food* was especially stressed in the *rural areas*.

As with drinking, *enjoyment/fun* as well as *mood-changing* ('to get alright, to calm my nerves') were the most popular reasons for *smoking*, although enjoyment/fun seemed more important to smokers than to drinkers (Appendix A, Table 23). (Again it should be noted that enjoyment and mood-changing were also especially emphasized in the replies to the open question concerning the main reason for smoking.) *Custom* ('because I'm used to it, because it is fashionable, because it is grown-up') was also fairly important to current smokers. *Social pressure* ('because my friends do so, so as not to be the odd one out, so that my friends won't think I'm scared') was also fairly frequently stressed by smokers. Substantial proportions underlined the matter of *coping* with various situations ('to give myself courage/confidence, to help me mix more easily with people') as reason for smoking.

Regarding the use of *solvents, enjoyment* ('it is fun'), *custom* ('my friends do it, used to it') and *mood-changing* ('makes me feel alright', makes me feel drunk') were particularly popular reasons for use (Appendix A, Table 23). Among solvent users in the *rural* areas *taking away the cold in winter* was also quite important.

With reference to *substances other than alcohol, cigarettes/tobacco and solvents,* users mostly gave as their *main reason for use,* 'it gives me energy/stamina' (Appendix A, Table 23).

Context within which alcohol, tobacco and other drugs are used

Whereas the emphasis with regard to *drinking and smoking* was on doing so *in company or in company and alone,* the *opposite applied to other substances* (Appendix A, Table 25). Indeed, substantial proportions (between 49,9 per cent and 59,6 per cent) of the current users of substances other than alcohol and cigarettes or tobacco stated that they mostly used these substances when they were alone.

The single largest proportions of the current *drinkers* and *smokers* of cigarettes or tobacco pointed out that they mostly did so in the *company of friends* (*same age or younger*); in the case of *other substances, relatives* were mentioned in this respect, although major proportions were not prepared to say, or could not, in whose company they mostly used these substances (Appendix A, Table 25). It should also be noted that among those respondents who said that they *mostly drank alcohol in the company of friends* (same age or younger), the younger age group (*10-13 years*) was particularly well represented.

Concerning the *place* where current *drinkers mostly used alcohol, shebeens/taverns* were particularly emphasized by *males* (as was the case in the 1990 study (Rocha-Silva, 1991a, 1991b) among largely adults (Appendix A, Table 26); *females mostly used their own homes* (whether parents/guardians were in/out) (Appendix A, Table 25). Demographic analyses showed that the *popularity of shebeens progressively increased with age* among the young people (Figure 40). In the oldest age group (*18-21 years*) *shebeens* were *especially important to male drinkers.* In the age group *14-17 years,* visits to shebeens were particularly common among those who said that they *had attended festivities* in the 12 months prior to the present study.

Clubs/discothèques were fairly popular among *male drinkers in more urbanized areas* (as was the case in the 1990 adult survey (Appendix A, Table 26)); and *bottle-stores among males in the rural areas.* The *homes of friends* were fairly popular with *drinkers in the rural areas;* and *with females in the urban areas.*

Among *smokers of cigarettes or tobacco, own homes* generally seemed to be preferred to other places, although the general trend seemed to be that they smoked when their *parents/guardians were out.* Substantial proportions of the smokers in the *urbanized areas,* as well as of the *female smokers in the rural areas,* stated that they mostly smoked at the *homes of friends.* Among *male smokers in rural areas,* a substantial proportion indicated that they mostly smoked *at school.* Concerning *substances other than alcohol and cigarettes or tobacco,* the majority of the current users said that they *mostly used the relevant substances in their own homes.* (The latter particularly applied to the younger age group (*10-13 years*) and *females in the older age group* (14 years and older).)

The single largest proportions of current drinkers in the urbanized areas indicated that they usually took their first drink of the day at night, although substantial proportions started at lunch-time; indeed, the proportions in the various categories generally increased progressively towards night-time (Appendix A, Table 25). The single largest proportion of the male drinkers in the rural areas mostly started at lunch-time and the proportions generally decreased towards night-time. Female drinkers in the rural areas, generally started after lunch but before the evening meal. *Noteworthy proportions (between 5,0 per cent and 9,7 per cent) of the current drinkers said that they took their first drink of the day when they woke in the morning* (Appendix A, Table 25). What is disturbing is that these percentages more or less parallel those in the 1990 adult survey (Appendix A, Table 26). It should also be noted that young drinkers who either *started to drink when they woke in the morning or at lunch-time particularly included people who* said that they *had attended traditional ceremonies* in the 12 months prior to the present study.

Among *smokers of cigarettes/tobacco,* the *majority* (between 44,4 per cent and 77,1 per cent) generally took their *first cigarette or pipe when they woke in the morning* (Appendix A, Table 25).

It is also important to note that fair proportions (between 5,9 per cent and 16,7 per cent) of the young people in the present study who reported current use of alcohol or drugs pointed out that they had been *beaten by friends or parents* because of their drinking or drug taking (Appendix A, Table 27).

With regard to social pressure to use alcohol and/or other drugs, it is important to note that the young people in this study reported *fairly substantial pressure in various forms, particularly with regard to alcohol and,* to a lesser extent, *cigarettes or tobacco.* This was generally more marked among *males* than females and more so among males in the *rural* than *urban areas* (Appendix A, Table 29). Apart from pressure to drink or smoke cigarettes/tobacco, *fair* proportions of the males reported *pressure to use* dagga. The proportions that reported pressure to use a mixture of mandrax and dagga (white pipe) were generally somewhat lower than in the case of *solvent use.* What is also important is that the proportions, particularly in the rural areas (former TBVC and self-governing states), who experienced *pressure to use substances other than alcohol, cigarettes/ tobacco, dagga, white pipe and solvents are noteworthy* (between 4,8 per cent and 17,6 per cent).

Note should also be taken of the fact that the young people who replied affirmatively to the question, 'Do your friends/relatives ever try to persuade you to have a or another drink?', were particularly those who were *married or involved with the opposite sex, male* and had *attended traditional ceremonies* in the 12 months prior to the study.

HIV infection/AIDS-related matters

World-wide alcohol and other drug use have been identified as potentially risky practices in terms of contracting and transmitting the HI virus. Of particular concern are the indications that HIV infection among users of alcohol, tobacco and other drugs, in particular comparatively *heavy* users, has the potential for playing a major role in the escalation of the HIV epidemic through such users' association with groups who would otherwise not be at risk. Attention is also drawn to the comparatively heavy burden HIV infected persons with a comparatively *heavy* alcohol, tobacco and other drug intake can be expected to place on specialized treatment facilities and health care generally.

Although practical difficulties hampered a detailed exploration of alcohol- and other drug-related HIV infection/AIDS matters in the present study, some attention was given to the young respondents' level of knowledge regarding the nature of HIV infection/AIDS and information needs.

In this respect it should be noted that the majority of the respondents (between 52,8 per cent and 63,3 per cent) knew about AIDS and major proportions of these reported it to be a 'sexually transmitted disease' (between 30,3 per cent and 52,8 per cent) or said that it was a 'killer/dangerous/incurable disease' (between 35,4 per cent and 52,3 per cent).

The young people in this study also generally replied affirmatively to the question: 'Do you or don't you think young people need more information about AIDS?'. However, major proportions (between 42,0 per cent and 53,3 per cent) did not think it was necessary (Appendix A, Table 32). Those who thought it was necessary emphasized matters such as the prevention and causes of the disease.

Some of the respondents (between 0,8 per cent and 4,2 per cent) stated that they had been tested for HIV infection. In the total sample, three respondents admitted that the virus had been identified in them.

Section 4

Discussion: Areas of risk related to alcohol, tobacco and other drugs

Introduction

In the light of the fact that this study aims to provide preventive agents in the field of alcohol-, tobacco- and other drug-related problems with a concrete basis in terms of which their programmes may be devised, this section will *summarize* the research findings by indicating areas of risk with regard to the development of problems related to these substances. Consideration will be given to the findings of both the survey and the in-depth qualitative study. A special attempt will be made to ascertain to what extent the present study has substantiated and refined the survey findings. Discussion will centre around the survey results.

More specifically, in line with the Public Health Model of prevention (Rocha-Silva, 1992), the findings will be scrutinized for areas of *individual* and *environmental* oriented risk-proneness in terms of the development of alcohol-, tobacco- and other drug-related problems. Consideration will be given to the young people's

- level of alcohol, tobacco and other drug consumption,
- the age of onset of drinking, smoking and other drug-taking,
- reasons for the initiation and current use of alcohol, tobacco and other drugs,
- the context within which alcohol, tobacco and other drugs are used,
- whether current users of alcohol, tobacco and other drugs experienced problems related to their drinking, smoking and other drug-taking,
- whether current alcohol, tobacco and other drug users ever felt a need for help/advice in connection with their drinking, smoking or other drug taking, and

- the extent to which respondents experienced outside pressure to drink, smoke or take other drugs.

In fact, a special attempt will be made to ascertain whether (a) environmental factors, such as exposure to, social support for, and access to alcohol, tobacco and other drug use, as well as an absence of social discrimination against such use; and (b) the psychological parallels of these environmental factors impinged on the young people concerned.

Level of alcohol consumption

In this section, the broader drinking structure among the young people concerned will be discussed and placed in perspective first, before areas of risk-proneness are identified in some detail.

A *substantial proportion* (34,0 per cent) of the young people were current drinkers (used alcohol in the 12 months prior to the study). (Approximately two fifths (42,5 per cent) had taken alcohol (*a proper drink of alcohol*) at some time in their lives.) Indeed, it seems that the proportion of current drinkers among the young people was substantially lower than the proportions among their adult counterparts (Rocha-Silva, 1992). It is clear though, as was shown in the qualitative part of the present study, that drinking was not uncommon among young people.

Although comparative national data on the drinking practices of young people in black households are not available, attention should be drawn to the fact that the proportion (26,9 per cent) of current drinkers in a 1990 study in the Cape Peninsula among historically advantaged *and* disadvantaged secondary school children was somewhat lower than was the case in the present study. The Cape Peninsula study, however, defined current drinking (alcohol use on at least one occasion in the week preceding the study) more restrictively than was the case in the present study.

Moreover, in line with overseas (Fossey, 1994) and local findings (Flisher *et al.*, 1993), the *proportion of current drinkers in the present study increased with age, especially among males*. (This is supported by the insights that emerged in the course of the qualitative part of the present study.) In fact, as is generally the case throughout the world, current drinking among young people seems to be a male phenomenon, in particular. Important also is that the present study suggests a connection between drinking and (a) *attendance of festivities* (such as weddings, birthday parties, the unveiling of tombstones and traditional ceremonies in African culture), as well as (b) *a lack of involvement with institutions such as the church*. Indeed, it seems that youthful drinking may (to some extent) be connected with fairly *uncontrolled* social activity.

With regard to alcoholic beverage preferences, the young people generally reflected adult patterns (Rocha-Silva, 1992). The drinking of distilled spirits was generally more common than wine drinking among male drinkers. Indeed, users of distilled spirits were particularly males, and especially those in the older rather than younger age category. The popularity of distilled spirits among males is somewhat disturbing in view of (a) the fairly high absolute alcohol content of distilled spirits and (b) the argument that the level of absolute alcohol intake is associated with the level of occurrence of related problems (Davies & Walsh, 1983). However, as has been traditionally the case in African culture, beer was the most popular alcoholic beverage among male drinkers in the present study, particularly among those in the older age groups.

Wine drinking seems to have been particularly popular among females. This trend has also been identified in various overseas studies (Fossey, 1994). Generally, the young *female drinkers* manifested, *as* did their *adult counterparts*, a fairly *homogeneous beverage preference pattern* with regard to the use of beer, wine and cider. There was also some suggestion that *female use of beer and distilled spirits* was *intertwined with being married or having a boyfriend* and thus, possibly, with so-called *maturity*. (It may also be, as has been noted by practitioners, that alcohol played a maintaining or facilitating role in relationships between members of the opposite sex.) *Female wine drinking* seems to have been linked to *'adulthood' and attendance of festivities*. It was particularly popular among the older age group and those who attended festive gatherings.

The present study also suggests that *home-made liquor* was associated with *tradition*. It was particularly popular among young people who attended traditional African ceremonies, especially in rural areas.

While regular drinking (imbibing an alcoholic beverage at least once a week), as was also found by Nkonzo-Mtembu (1994) in KwaZulu-Natal, seemed to be less common among the young drinkers than among their adult counterparts, preventive agents should note that *major proportions of the young drinkers consumed distilled spirits (the alcoholic beverage with the highest absolute alcohol content) at least once a week*. This study also supports the finding in related local (Flisher *et al.*, 1993) and overseas (Fossey, 1994) studies that *regular drinking* among the youth is more common among the *older* than younger age groups.

As is the case with frequency of consumption, the young people apparently generally imbibed lower volumes of alcohol than their adult counterparts (Rocha-Silva, 1992). However, in the light of the argument that a comparatively high intake of alcohol is conducive to the development of alcohol-related problems, preventive agents should take special note that this study suggests that *noteworthy proportions of the young people drank comparatively heavily* in terms of general standards (Fossey, 1994:31; Loretto, 1994:148). This finding is to some extent supported by the previously mentioned 1990 study in the Cape Peninsula (Flisher *et al.*, 1993), and a 1989 survey in KwaZulu-Natal (Nkonzo-Mtembu, 1994). In fact, fair to substantial proportions of the young people imbibed at least 49 cl absolute alcohol on average per week, or at least 7 cl absolute alcohol on average per day. Indeed, it may be that Fossey's (1994:31) observation, that young people's level of intake can (on occasion) exceed so-called *adult* levels, applies to some extent to young people in this study, or at least to certain of the male drinkers. (As has been established overseas and to some extent locally (Fossey, 1994; Flisher *et al.*, 1993), *the volume of consumption increased with age and was more marked among males.*) Note should also be taken that a comparatively high volume of intake seems to have been associated with being *married* or *having a boy or girlfriend, having children* and *not being involved with institutions such as the church.*

Level of intake of tobacco and drugs other than alcohol

Apart from *over-the-counter pain-relievers, and over-the-counter medicine generally, cigarettes or tobacco* were the most common substances other than alcohol that were used by the young people. This correlates with general trends among their adult counterparts

(Rocha-Silva, 1992). (Note should also be taken that the present study suggests that the prevalence of cigarette or tobacco smoking was less common among historically disadvantaged young people in South Africa in general, than it appeared to be in more restricted areas such as the Cape Peninsula (Flisher *et al.*, 1993).)

Cognizance should also be taken of indications that *smokers of cigarettes or tobacco are very often also drinkers of alcohol.* This ties in to some extent with the fairly widely accepted assumption that a stepwise progression from smoking to alcohol or *vice versa,* manifests among young people. In this respect, note should also be taken of the finding that smokers of cigarettes or tobacco, who at some time also took a drink of alcohol, mostly said that they had their first smoke before their first drink. Substantial proportions, however, reported it to be the other way round. Moreover, as was found in related local and overseas studies (Flisher *et al.*, 1993; Fossey, 1994), the *smoking of cigarettes/tobacco seems to have been particularly prevalent among the older rather than younger age groups and especially among males.*

The use of dagga, LSD, cocaine, heroin and non-prescriptive narcotics (other than heroin) seems to have been less common among the young people than their adult counterparts. Preventive agents should, however, note that *sedatives, tranquilizers and stimulants* were apparently more common among the young people than among their adult counterparts (Rocha-Silva, 1992).

Special attention should also be drawn to the fact that *lifetime use of substances such as cocaine, LSD and heroin* was apparently more prevalent among black youngsters in South Africa in general than in the Cape Peninsula (Flisher *et al.*, 1993).

The proportions among the young people in the national survey (7,4 per cent) who admitted current use of *solvents/inhalants* were somewhat lower than the proportions in the 1990 Cape Peninsula study (10,9 per cent) (Flisher *et al.*, 1993). It may thus be fairly safe to say that the proportion of solvent users among black youngsters in South Africa could be in the order of 10,0 per cent or lower.

The *regular intake (at least once a week)* of substances other than alcohol applied to *cigarettes and tobacco, in particular, and to some extent to dagga.* Indeed, *smokers of cigarettes or tobacco mostly smoked* regularly and *heavily* (at least two cigarettes or pipes a day).

First use of alcohol, tobacco and other drugs

Generally, and to some extent in line with overseas research (Fossey, 1994), the *age of onset* with regard to the use of alcohol, cigarettes, tobacco and dagga was mostly in the age category *14-17 years.* In the case of *solvents,* it seems to have been somewhat *younger.*

Bearing in mind that the initiation of alcohol, tobacco and other drug use within fairly *uncontrolled* social circumstances is generally regarded as indicative of risk-proneness in terms of the development of alcohol- and drug-related problems, note should be taken that *friends* (same age or younger) were especially indicated by young people as the persons from whom they got their first drink, cigarette or tobacco. Moreover, as was to some extent found in the qualitative part of this study, substantial proportions of young people apparently got their first drink, cigarettes or tobacco themselves. However, there were also some tentative indications that the younger the person concerned, the more likely it was that relatives would provide his or her first drink, cigarette or tobacco. Overseas findings, that '... alcohol consumption shifts ... out of the "private" sphere of family life into the public domain' the older a young person gets (May, 1992:111), may thus also apply to local young people.

As the first experience of alcohol or cigarettes may impact on decisions to drink or smoke again, it should be noted that young drinkers experienced their *first drink of alcohol as mostly 'nice'* (especially in metropolitan centres and in rural areas). The *opposite* applied in the case of the *first cigarette or tobacco.* However, smokers in the older age group (*18-21 years*) mostly reported that they wanted to smoke again after their first cigarette or tobacco. *Drinkers,* in particular, and especially *males* in the older age group (*18-21 years*), said that they *wanted to drink again after their first drink.* Most importantly, in the case of both drinking and smoking, substantial proportions (particularly males, and especially those in rural areas) of the relevant young people were of the opinion that *they were likely to drink and or smoke when they got older.* This is particularly important if cognizance is taken of evidence that a major contributory factor to the continuation and onset of drinking/ smoking of cigarettes/tobacco among young people has been shown to be the belief that they were likely to drink or smoke when they were older (Fossey, 1994). The *first try at solvents* was, however, mostly *experienced negatively* by solvent users. This is supported by the qualitative research of the present study.

With regard to *reasons for the first try at alcohol, cigarettes or tobacco, and solvents,* note should be taken that, in line with a number of overseas studies (Fossey, 1994), *experimentation, pressure from friends,* *and fun* were particularly popular among the young people concerned. Moreover, in the case of drinking, fun seems to have been particularly important to the older age group (*17 years and older*), especially to those in rural areas and urbanized towns. Experimentation seems to have been particularly of concern in the case of smokers. Pressure from friends seems to apply, especially to smokers in informal settlements and rural areas.

Reasons for using or not using alcohol, tobacco and other drugs

Insight into why young people sometimes *did not use alcohol, tobacco and other drugs* may assist agents in devising preventive programmes that emphasize these factors. Note should thus be taken that a particularly popular reason for *not using alcohol/cigarettes/tobacco* was apparently the belief that usage of these substances is *bad* for one's health and, indeed, for one's life in general. As was found in overseas studies, the latter particularly applied to cigarettes/tobacco (Fossey, 1994). In the case of drinking, the reasons mentioned particularly applied to the older age group (*18-21 years*), and especially to those who were involved in the church. In this respect, note should be taken of the finding in the in-depth qualitative study that young people associated drinking, in particular, but also other drugs, with matters such as sexual abuse (rape), violence and crime.

Significantly, a *personal decision not to smoke* was a point made by substantial proportions of those who did not smoke. In metropolitan centres, pressure from friends not to drink or smoke was quite common. Disapproval from parents, guardians or spouses was fairly frequently mentioned as a reason for not smoking by those who did not use cigarettes or tobacco in metropolitan centres and informal settlements. It should also be noted that the *cost of smoking* was reported as a deterrent to smoking.

It is generally assumed by practitioners that when alcohol or other drugs are used for reasons such as *coping* with life and mood-changing, a degree of risk is involved in terms of the development of alcohol/drug-related problems. Preventive agents should, therefore, note that *mood-changing, enjoyment or fun* and *experimentation* seem to have ranked fairly highly among the young people as reasons for *drinking*. Enjoyment particularly applied to the comparatively older age groups and, in the case of the younger ones, those in metropolitan centres. In this respect, attention should be drawn to the fact that the in-depth qualitative study supported the survey finding that mood-changing was a major reason for drinking and, indeed, drug taking generally. A need to *'feel better/okay'* seems to have been stronger than a need to avoid unfavourable consequences of alcohol, tobacco or other drug use. Indeed, the in-depth study to some extent showed that the need for mood-changing may have been closely intertwined with a need to cope with, or, for that matter, escape or opt out of, unfavourable life circumstances. *Social pressure* was also a quite popular reason for drinking. This was borne out in both the survey and qualitative study. That *drinking was regarded as a form of food* applied especially to drinkers in *rural areas.*

With regard to *smoking, enjoyment or fun* was a particularly popular reason given for using cigarettes or tobacco. However, *mood-changing, social pressure, coping with life,* and *custom* were also quite common reasons. In the case of *solvents, enjoyment, custom, and mood-*

changing, and in the case of rural areas, *takes away the cold in winter* were the most prevalent reasons for usage. The in-depth study showed that feelings of *strength* and *oblivion* were particularly associated with solvent use. In respect of *substances other than alcohol, cigarettes and solvents, energy or stamina* was an important reason for the relevant respondents. (In the latter respect, note should be taken that the substances of concern were mostly over-the-counter medicine, including *inter alia* pain-relievers.) Preventive agents need, however, also to bear in mind what emerged from the in-depth qualitative study concerning reasons for using cannabis, namely, that it was believed to contribute to extra-sensory experiences and, indeed, *protection* from what is unfavourable.

Context within which alcohol, tobacco and other drugs are used

Whereas *drinking and cigarette or tobacco smoking* mostly occurred *in company*, the opposite applied to other substances. (In this respect note should be taken that the latter substances mostly applied to the use of over-the-counter medicine generally and pain-relievers, in particular.) Moreover, the more private and possibly more *controlled* domain of one's home and the company of relatives seem to have been the setting and type of company preferred in the case of over-the-counter medicine generally and pain-relievers in particular. With regard to *drinking and smoking of cigarettes/tobacco*, possibly more *uncontrolled* circumstances applied. The latter substances were particularly used *in the company of friends or peers* (same age or younger). Indeed, it seems fair to conclude that the young drinkers and smokers of cigarettes and tobacco used alcohol or cigarettes in social settings in which pressure was most probably put on them to use the relevant substances. This is substantiated by the fact that *public drinking places, such as shebeens and taverns, clubs and discothèques, and bottle-stores* (where the emphasis was most probably on drinking rather than on other activities) were especially popular among *male drinkers*. The fact that taverns *increased in popularity with age*, among male drinkers especially, possibly reflects, as noted by May (1992:111), 'a ... transition to "adult" social relations'. Urban *female drinkers* and, to some extent, drinkers in rural areas seem to have preferred to drink in less public places, but possibly still fairly *uncontrolled* circumstances, namely at the *homes of friends*.

With regard to the *smoking of cigarettes or tobacco*, the relevant young people's *own homes* seem to have been particularly popular. Smoking, however, seems to have occurred especially when *parents or guardians were out*, and thus most probably in less *controlled* circumstances. The *homes of friends* were also fairly popular among smokers. This applied especially to *female smokers in rural areas*. Cognizance should, however, also be taken of the fact that noteworthy proportions of *male smokers in rural areas* indicated the *school* as the place where they mostly smoked.

In the light of the fact that morning drinking is widely accepted as an indication of *risky or heavy* drinking in terms of the development of related problems, special attention needs to be drawn to the finding that *noteworthy proportions* among the young drinkers in this study reported taking *a drink first thing in the morning* when they woke. What is most disturbing is that these proportions approximate those among their adult counterparts. It is also significant that the young drinkers who drank first thing in the morning, or at least at and before lunch-time were particularly people who *attended festive gatherings*, such as weddings, birthdays and the unveiling of tombstones. Moreover, by far the majority of *smokers of cigarettes or tobacco took their first cigarette or pipe when they woke in the morning*.

Noteworthy proportions of the young drinkers and drug takers had *negative experiences associated with drinking or drug taking*.

Note should also be taken of the fact that substantial proportions of the young people directly reported in the present survey that they had experienced social pressure in various forms to drink and, though to a lesser extent, to smoke cigarettes or tobacco. A fair amount of social pressure on young people to use dagga and, to a lesser extent, solvents and other substances was also suggested in the survey. This was substantiated in the in-depth qualitative findings.

Summary

In brief, the survey findings and the insights that emerged during the in-depth qualitative study show that the young people manifested a fair degree of risk-proneness with regard to the development of alcohol-, tobacco- and other drug-related problems. In fact, in line with this study's assumptions concerning factors contributing to such problems, the research findings indicate[11] that the young people found themselves in a social *environment* in which there was a fair degree of:

- *Social support* for alcohol, tobacco and other drug use.
- *Exposure* to alcohol, tobacco and other drug use.

---

[11] See diagram at end of this section page 82.

- *Limited discrimination* against alcohol, tobacco and other drug use.

It is also clear that these social factors had a psychological impact on the young people concerned. There were indications of *tolerance* towards alcohol, tobacco and other drug use, *limited fear of discrimination against its use* and a personal *need* for or *attraction* to alcohol, tobacco and other drug intake. Acquaintance with and, indeed, actual *use* of alcohol, tobacco and other drugs were also not unusual among the young people.

More specifically, preventive agents need to take cognizance of the following:

- The use of licit drugs such as over-the-counter medicine, alcohol, cigarettes and tobacco and, to some extent, non-prescriptive sedatives, tranquilizers and stimulants seems to have been fairly prevalent among the young people.
- Drinking and smoking of cigarettes and tobacco clearly differentiated in terms of gender, with both being especially male phenomena.
- Drinking and the smoking of cigarettes or tobacco tended to go together, and seem to have been part of entry into adulthood, especially among males; the same applied to regular (at least once a week) drinking and the intake of comparatively high quantities.
- Male drinkers manifested a preference for ordinary beer and distilled spirits, while wine was particularly popular among female drinkers, and the use of beer and distilled spirits seems to have been connected in some way with female drinkers' relationships with the opposite sex.

- The drinking of distilled spirits, and then a fairly regular intake (at least once a week), seems to have been fairly popular, especially among male drinkers, and to increase in popularity with age.
- A comparatively *heavy* level of absolute alcohol intake and morning drinking, which were clear indications of a comparatively high degree of risk-proneness in terms of the development of alcohol-related problems, were not totally uncommon among the drinkers — this applied to males in particular, and especially the older ones.
- The use of cigarettes and or tobacco, although not as common as alcoholic beverages, manifested particularly in the form of regular and comparatively heavy intake.
- Initiation into drinking and smoking of cigarettes or tobacco tended to occur in *uncontrolled* rather than *controlled* social circumstances, with friends being particularly the suppliers, although it seems that it was not uncommon for the young people to get their first drink or cigarette or tobacco themselves.
- Reasons for the first try at alcohol, cigarettes or tobacco and solvents tended to be experimentation (particularly with regard to cigarettes or tobacco), pressure from friends, and fun (particularly with regard to alcohol and the comparatively older age groups in especially rural areas and urbanized towns).
- While first experiences of alcohol seem to have been positive (*'nice'*), the opposite applied to smoking, although the negative experiences did not seem to act as a deterrent to trying another cigarette or tobacco.
- Associations between drinking and smoking of cigarettes or tobacco and unfavourable biological (ill health) and social

circumstances seemingly tended to influence decisions to abstain from alcohol and cigarettes or tobacco (in the case of cigarettes or tobacco, the financial impact of such use seems to have weighed fairly heavily).

- Reasons for drinking tended to focus on mood-changing, enjoyment or fun and social pressure (in rural areas there seems to have been a tendency to associate drinking with food); in the case of smoking, enjoyment or fun seems to have been particularly important.
- Substances other than alcohol and cigarettes or tobacco, and especially over-the-counter medicine, seem to have been used in order to increase energy or stamina.
- Drinking tended to take place in company and fairly *uncontrolled* social settings, where a fair degree of pressure to use alcohol could be expected — taverns and shebeens, bottle-stores, clubs and discothèques were, for example, particularly popular drinking places among male drinkers, and the homes of friends among female drinkers.
- Smoking cigarettes was also seemingly a fairly *uncontrolled* group activity (for example, the homes of friends were apparently a fairly popular place for smoking. Smoking at youngsters' own homes tended to take place when parents or guardians were absent, while in the case of rural residents, schools seem to have been popular).
- Direct social pressure to use alcohol, tobacco and other drugs had been experienced by noteworthy proportions of the young people.
- Reasonable proportions of current users of alcohol, tobacco and other drugs reported negative experiences related to their use of these substances.

Finally, the fact that this study suggests that young people in black households in South Africa manifested, in terms of drinking, smoking and other drug-taking practices and related attitudes, a fair level of risk-proneness, has serious implications in terms of HIV infection/AIDS. Of particular importance are the indications that a comparatively *heavy* alcohol intake was not altogether uncommon among these youngsters. This is widely recognized as a risk practice in terms of HIV infection. In this respect, special note should be taken that some of the youngsters in the present survey admitted that HIV had been identified in them. Indeed, the possibility of the youngsters being at fairly high risk where contracting HIV is concerned (as is to some extent suggested in this study) is exacerbated by their apparently fairly superficial knowledge regarding the nature of HIV infection/AIDS.

Summary of areas of risk-proneness with regard to the development of alcohol/drug-related problems (Rocha-Silva Model)[*]

Social factors	Psychological factors	Alcohol/drug intake: related problems
Social support/pressure to use alcohol/tobacco/drugs; exposure to alcohol/tobacco/drug use; little discrimination against alcohol/tobacco/drug use, e.g.	*Acquainted with alcohol/tobacco/drug use; tolerant towards alcohol/drug taking; believing that alcohol/tobacco/drug taking will not be discriminated against; personal need for/attraction to alcohol/tobacco/drug taking; believing in the rewarding nature of alcohol/drug taking, e.g.*	◆ Intake of the over-the-counter medicine, alcohol, cigarettes or tobacco, non-prescriptive sedatives, tranquilisers, stimulants particularly prevalent.
◆ Friends supplied first drink and first cigarette/tobacco; friends/relatives tried to persuade young person to have a/another drink/drug; got first drink and first cigarette/tobacco themselves	◆ Reasons for first try: Experiment, enjoyment/fun; prepared to have another drink/cigarette/tobacco after first.	◆ Drinking and smoking cigarettes or tobacco associated, particularly prevalent among older groups (especially males); a fairly high intake (including morning drinking) among particularly (older) males.
◆ Drinking in company and at places where the focus is on drinking (taverns, bottle stores, clubs/discothèques); drinking at homes of friends; smoking cigarettes/tobacco at friends' homes or at own homes when parents or guardians are away.	◆ Reasons for (a) drinking and smoking of cigarettes/tobacco: mood-changing, enjoyment/fun; (b) other drugs: increased energy/stamina; coping with life/escaping from detrimental life circumstances (qualitative findings).	◆ Male drinkers: Beer and distilled spirits popular; female drinkers: preference for wine; female drinking of beer and distilled spirits associated with being married/having a boyfriend.
◆ Risk-prone alcohol/drug-related practices and limited social sanctions in parental home (qualitative findings).	◆ Young males fairly unconcerned about the possibility of social discrimination; positive associations with drinking/smoking/drug taking (for example, belief that the intake of dagga can protect/strengthen against harm (qualitative findings).	◆ Drinking associated with attendance of festivities and lack of church involvement. ◆ Alcohol/drug-related problems experienced

[*] Rocha-Silva, L. 1992. *Alcohol/drug-related research in the RSA: Meeting the challenge of the 1990s.* Pretoria: Human Sciences Research Council

Section 5

Closing remarks: Preventive guidelines

Background

This study suggests risk-proneness with regard to the development of alcohol-, tobacco- and other drug-related problems (including HIV infection/AIDS) at various levels among young black South Africans. This fact, as well as the present rather unstable socio-economic climate in South Africa, and the public health implications of a future increase in alcohol-, tobacco- and other drug-related problems, particularly HIV infection/AIDS among the youngsters, creates *great pressure for cost-effective and innovative prevention programmes in the field of alcohol/drug-related problems* with special emphasis on HIV infection.

Some attempt will be made in this section to suggest guidelines for prevention. It needs to be stressed, though, that in view of the importance of establishing preventive measures that are acceptable to the young people themselves and in which they take an active part, detailed pre-formulated programmes are inadvisable. The guidelines in the following paragraphs should thus be viewed as broad directives rather than finite procedural premises. Indeed, to avoid the pitfall of arrogance, these guidelines are suggested as a basis for debate rather than a final statement concerning prevention. However, they do lean heavily on the present research findings and relevant overseas experience in the prevention field.

It should also be noted that, historically, it seems that efforts at prevention within the context of alcohol, tobacco and other drug-related problems can generally claim *risk reduction,* and not risk elimination. Thus, it is not surprising that the so-called 'demand reduction' approach has gained substantial support in the international world. The *hard touch* or *absolute control* of the so-called *'war-on-alcohol/drugs'* approach does not seem to have borne the expected fruit. However, the tendency of prevention efforts to focus on *either* individuals (as propagated by the demand reduction philosophy) *or* on alcohol/drugs (as supported by the availability restrictions philosophy) has also been found lacking. Instead, the more comprehensive approach of the public health philosophy is gaining popularity. It is argued that, in the process of developing prevention programmes, detailed attention needs to be given, not only to the individuals to be reached, but also to the prevention agents and to the broader environment within which prevention programmes are to be implemented. A warning is issued against a simplistic approach, against, for example, *blaming* one particular substance or activity to the exclusion of all other factors. Special emphasis is laid on the need for reaching out to targeted individuals, not as if they are objects to be acted upon but subjects who can contribute ideas and actions on their own, who can, to some extent, determine their own history.

Moreover, the advice of the World Health Organization (WHO, 1980:29) given some years ago, seems increasingly to be being heeded by prevention agents. In fact, the value of developing prevention programmes within a framework of the health promotion of individuals and society at large so that 'prevention ... [is] seen as oriented towards goals that are inherently positive and salutary', is apparently gaining increasing recognition.

Recommendations

Indeed, in the light of the above notes on prevention issues, and present and past research findings on the acceptability of various types of services in the communities concerned, it is suggested that agents in the prevention field give serious consideration to the now firmly established research indications that medically-oriented alcohol/drug-related services are particularly acceptable to black households in South Africa (Rocha-Silva, 1992).[12] They will, however, also have to bear in mind that the importance of specialized alcohol/drug-related services, including social work, is fairly widely recognized among both the youngsters in the present study and their adult counterparts in earlier related studies. Note will have to be taken that the church, to some extent, seems to be seen by young people as playing a role in service delivery. (In this respect, it needs to be remembered that this study has shown that lack of involvement in an institution such as the church correlates with risk-prone alcohol/drug practices.)

In fact, it seems feasible to emphasize the need to formulate and implement comprehensive multi-faceted prevention programmes that lean on specialized alcohol/drug-related services, as well as on more generic broad-brush services within both social welfare and health. In this respect, consideration will probably have to be given to the value of primary health clinics in terms of providing accessible, affordable and acceptable alcohol/drug-related services.[13]

---

[12] As has been repeatedly suggested in past research with regard to adults (Rocha-Silva, 1992), the present study among young people underlines medically oriented alcohol/drug-related services as the best known and most acceptable service (between 56,8 per cent and 73,1 per cent of the respondents said that they would refer a friend who needed help with regard to his/her drinking/smoking/drugging to a medical doctor; the comparative percentages for a health clinic were 60,8 per cent and 74,1 per cent (Appendix A, Table 31)). Social workers were also quite popular (between 60,0 per cent and 71,5 per cent said that they would refer a friend in need to such a person). SANCA clinics were more important to respondents in the urbanized that the rural areas. Generally, church agents were preferred to family and friends, although major proportions were willing to refer a person in need to family and friends.

[13] In this respect the WHO's manual for community health workers needs to be noted (WHO, 1986), as well as its information document on compiling guidelines for local action (WHO, 1991).

Finally, explicit recognition will have to be given to the need for youth participation in the formulation and implementation of prevention programmes; to the important role the church needs to play, and thus the need for founding prevention programmes on the spiritual component in life, i.e. on the *power that vitalizes and directs life functions and purposes for the good.*

More specifically, in terms of the above thoughts, the prevention-oriented theoretical framework within which the present study has been developed and the areas of risk with regard to the development of alcohol/drug-related problems that have emerged, the following directions or guidelines regarding prevention are offered:

Prevention focuses

Areas of particular note for prevention agents are:

Behavioural and social interactional factors

- The use of over-the-counter medicine, alcohol, cigarettes/tobacco, and solvents.
- Male drinking/smoking of cigarettes.
- Wine drinking among females.
- *Heavy* alcohol/cigarette/tobacco use.
- Morning drinking/smoking of cigarettes/tobacco.
- Drinking/smoking of cigarettes as part and parcel of entering adulthood.
- The drinking of distilled spirits.
- Group-use of alcohol/drugs in fairly *uncontrolled/unregulated* public settings.

- General social pressure to drink or smoke cigarettes/tobacco.
- The use of alcohol at festive gatherings.
- Lack of involvement in institutions such as the church.
- Family disintegration.

Attitudinal factors

- Drinking/drugging to experiment, to effect mood change, to have fun, to cope with life, to appease hunger and to take away the cold in winter.
- Superficial ideas on the nature, causes and transmission of HIV/ AIDS.

Prevention goals

Demand reduction

Focus on the individual and on educational programmes

- Topic/aim of educational programmes: The promotion of *healthy* lifestyles through *inter alia* culturally sensitive and targeted multi-media information campaigns, and the provision of generally accessible and appropriate skills-training programmes with regard to risk avoidance/reduction.
- Prevention agents: The public sector in partnership with the private sector; grassroot representation/participation; agents in as many fields of service as possible, but especially those in primary health care, in generic welfare services and in specialized alcohol-, tobacco- and other drug-related and treatment/prevention services, as well as those who have recovered from alcohol-, tobacco- and other drug-related problems.
- *General* target groups: Young people of all ages.

Focus on the environment

- Community development and work:
    - The setting up/strengthening of (in)formal social control structures in communities.
    - The setting up/strengthening of non-risk/*healthy* leisure time activities.
    - Redressing socio-economic societal conditions that are conducive to the development of alcohol-, tobacco- and other drug-related problems.
- Service delivery:
    - Specialized alcohol-, tobacco- and other drug-related prevention/treatment facilities.
    - Alcohol-, tobacco- and other drug-related services at primary health clinics (e.g. detoxification services, biological, psychological and social screening for risk-proneness with regard to alcohol- and drug-related problems, and a referral system with regard to specialized service needs, as well as a detailed information system that monitors the drinking/drug-taking practices and needs of users of services).
    - A detailed user-friendly and widely accessible register of national, provincial and municipal alcohol-, tobacco- and other drug-related prevention/treatment services.

Availability reduction

Focus on the individual

- General community participation in the formulation and implementation of restrictions on the production/distribution of alcohol and other drugs.

Focus on the environment

- Legal and other control measures with regard to access and exposure to alcohol, tobacco and other drug use.

Finally, it seems appropriate to emphasize that the formulation and implementation of cost-effective and rational prevention programmes, with regard to young people, in particular, will not be possible, unless they are explicitly research-based and the youth truly participate in the programme development and formulation. The following is therefore strongly recommended:

There should be a concrete investment in South African youth through *inter alia* (a) the facilitation of youth participation in preventive programmes, and (b) the continual and detailed monitoring of alcohol, tobacco and other drug practices/attitudes of young people, as well as the extent of alcohol-, tobacco- and other drug-related problems among them. In fact, a comprehensive and integrated alcohol-, tobacco- and other drug-related information base needs to be initiated and maintained on a national scale. This could be facilitated through the multi-sectoral drafting and implementation of an explicitly outlined, participative, national *management plan* (Pretorius, 1988).

Bibliography

Bagnall, G. & Plant, M.A. 1991. HIV/AIDS risks, alcohol and illicit drug use among young adults in areas of high and low rates of HIV infection. *AIDS Care*, 3(4):355-361.

Bagnall, G., Plant, M. & Warwick, W. 1990. Alcohol, drugs and AIDS-related risks: Results from a prospective study. *AIDS Care*, 2(4):309-317.

Beckman, V. 1988. *Alcohol: Another trap for Africa.* Orebro, Sweden: Libris.

Cooper, W.E., Schwar, T.G. & Smith, L.S. 1979. *Alcohol, drugs and road traffic.* Cape Town: Juta.

Council for Scientific and Industrial Research, Pretoria. 1994. Personal communication.

Davies, P. & Walsh, D. 1983. *Alcohol problems and alcohol control in Europe.* London: Croom Helm.

Department of Agriculture, Pretoria. 1994. Personal communication.

Department of Education and Culture. 1990. *Care for our youth 2000.* Pretoria: Government Printer.

Department of Health. 1994. *Information Bulletin*, 4(2):1-19.

Donato, F. *et al.* 1995. Patterns and covariates of alcohol drinking among high school students in ten towns in Italy: A cross-sectional study. *Drug and Alcohol Dependence*, 37:59-69.

Du Toit, S.H.C., Steyn, A.G.W. & Stumpf, R.H. 1984. *Statistical graphics.* Pretoria: Human Sciences Research Council.

Flisher, A.J. *et al.* 1993. Risk-taking behaviour of Cape Peninsula high school students. *South African Medical Journal*, 83(7):469-497.

Fossey, E. 1994. *Growing up with alcohol.* London: Routledge.

Fox, J. 1984. *Linear statistical models and related methods with applications to social research.* New York: John Wiley.

Frankel, B.G. & Whitehead, P.C. 1981. *Drinking and damage: Theoretical advances and implications for prevention*. New Brunswick, New Jersey: Rutgers Centre for Alcohol Studies.

Jessor, R. *et al.* 1968. *Society, personality and deviant behaviour*. New York: Holt, Rinehart & Winston.

Kerlinger, F.N. 1973. *Foundations of behavioral research*. New York: Holt, Rinehart & Winston.

Kirk, J. & Miller, M.L. 1986. *Reliability and validity in qualitative research*. Newburg Park: Sage.

Kuna, M.J. & Bande, T.M. 1993. Capitalism and drugs: A critique of conventional theories of substance abuse. *In*: Obot, I.S. (ed.). *Epidemiology and control of substance abuse in Nigeria*. University of Jos, Jos, Nigeria: Centre for Research and Information on Substance Abuse (CRISA).

Loretto, W.A. 1994. Youthful drinking in Northern Ireland and Scotland: Preliminary results from a comparative study. *Drugs: Education, Prevention and Policy*, 1(2):143-152.

Magwa, F. 1989. *The use and abuse of alcohol in Lesotho*. Maseru, Lesotho: Christian Council of Lesotho.

May, C. 1992. A burning issue? Adolescent alcohol use in Britain 1970-1991. *Alcohol and Alcoholism*, 27(2):109-115.

Molamu, L. 1988. *Use and abuse of alcohol in Southern Africa*. Proceedings of a regional symposium in Gaborone, Botswana, 27-30 June. Gaborone, Botswana: University of Botswana.

Mostert, W.P. & Van Tonder, J.L. 1987. *Projections of the South African population: 1985-2035*. Pretoria: Human Sciences Research Council.

Nkonzo-Mtembu, L.L. 1994. An investigation of the opinions of black adolescents on the Esikhawini area of KwaZulu in regard to the use and abuse of alcohol. *Curationis*, 17(4):50-53.

Obot, I.S. 1993a. *Drinking behaviour and attitudes in Nigeria: A general population survey in the Middle Belt*. University of Jos, Jos, Nigeria: Centre for Development Studies.

Obot, I.S. (ed.). 1993b. *Epidemiology and control of substance abuse in Nigeria*. University of Jos, Jos, Nigeria: Centre for Research and Information on Substance Abuse (CRISA).

Plant, M. 1992. *Risk-takers: Alcohol, drugs, sex and youth*. London: Routledge & Kegan Paul.

Plant, M.L., Plant, M.A. & Thomas, R.M. 1990. Alcohol, AIDS risks and commercial sex: Some preliminary results from a Scottish study. *Drug and Alcohol Dependence*, 25:51-55.

Pretorius, H.B. 1988. *On managing the traffic safety system: A multi-disciplinary approach*. (M Sc thesis.) Johannesburg: University of the Witwatersrand.

Rocha-Silva, L. 1987. Towards a more detailed measurement on quantity and frequency of alcohol intake of whites in the Republic of South Africa. *South African Journal of Sociology*, 18(4):133-138.

Rocha-Silva, L. 1991a. *Alcohol and other drug use by blacks resident in selected areas in the RSA*. Pretoria: Human Sciences Research Council.

Rocha-Silva, L. 1991b. *Alcohol and other drug use by residents of major districts in the self-governing states in South Africa*. Pretoria: Human Sciences Research Council.

Rocha-Silva, L. 1992. *Alcohol/drug-related research in the RSA: Meeting the challenge of the 1990s*. Pretoria: Human Sciences Research Council.

Tucker, B. & Scott, B.R. (eds). 1992. *South Africa: Prospects for successful transition*. Cape Town: Juta.

United Nations. 1990. *United Nations decade against drug abuse 1991-2000. Political Declaration and Global Programme of Action*. Geneva: United Nations.

United Nations Research Institute for Social Development. 1994. *Illicit drugs: Social impacts and policy responses*. Geneva: United Nations Research Institute for Social Development.

Van Vugt, J.P. (ed.). 1994. *AIDS prevention and services: Community based research*. London: Bergin & Garvey.

Watson, R.R. (ed.). 1990. *Drug and alcohol abuse prevention*. Clifton, New Jersey: Humana Press.

World Health Organization. 1980. *Problems related to alcohol consumption*. Geneva: World Health Organization.

World Health Organization. 1986. *Drug dependence and alcohol-related problems: A manual for community health workers with guidelines for trainers*. Geneva: World Health Organization.

World Health Organization. 1991. *Preventing alcohol problems: Local prevention activity and the compilation of 'Guides to local action'*. Geneva: World Health Organization.

World Health Organization. 1992. *Prevention and control of drug and alcohol abuse: Progress report by the Director-General*. Geneva: World Health Organization.

World Health Organization. 1993. *Alcohol and HIV/AIDS*. Geneva: World Health Organization.

World Health Organization. 1995. *Alcohol policy and the public good*. Oxford: World Health Organization.

Appendix A

Tables

Table 1: Honesty-screening responses in terms of place of residence

Place of residence	I would rather win than lose a game							
	Uncertain		**True**		**False**		**No response**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Metro	12	0,87	340	24,67	24	1,74	—	—
Rural/towns	25	1,81	277	20,10	20	1,45	1	0,07
Informal settlements	14	1,02	218	15,82	15	1,09	—	—
Deep rural	26	1,89	376	27,29	29	2,10	1	0,07
TOTAL	77	5,59	1 211	87,88	88	6,39	2	0,15

Place of residence	I have never told a lie, not even a tiny one							
	Uncertain		**True**		**False**		**No response**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Metro	31	2,25	79	5,73	266	19,30	—	—
Rural/towns	30	2,18	92	6,68	199	14,44	2	0,15
Informal settlements	24	1,74	54	3,92	169	12,26	—	—
Deep rural	35	2,54	121	8,78	275	19,96	1	0,07
TOTAL	120	8,71	346	25,11	909	65,97	3	0,22

Place of residence	I do not like everyone I know							
	Uncertain		**True**		**False**		**No response**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Metro	20	1,45	179	12,99	177	12,84	—	—
Rural/towns	29	2,10	120	8,71	172	12,48	2	0,15
Informal settlements	22	1,60	104	7,55	121	8,78	—	—
Deep rural	39	2,83	175	12,70	217	15,75	1	0,07
TOTAL	110	7,98	578	41,94	687	49,85	3	0,22

Table 1: Honestly-screening responses in terms of place of residence (continued)

Place of residence	At times I have felt like swearing							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Metro	24	1,74	204	14,80	147	10,67	1	0,07
Rural/towns	38	2,76	186	13,50	97	7,04	2	0,15
Informal settlements	31	2,25	142	10,30	74	5,37	—	—
Deep rural	37	2,69	236	17,13	157	11,39	2	0,15
TOTAL	130	9,43	768	55,73	475	34,47	5	0,36

Place of residence	I would probably get into a movie without ...							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Metro	34	2,47	125	9,07	217	15,75	—	—
Rural/towns	39	2,83	106	7,69	176	12,77	2	0,15
Informal settlements	25	1,81	79	5,73	142	10,30	1	0,07
Deep rural	54	3,92	181	13,13	196	14,22	1	0,07
TOTAL	152	11,03	491	35,63	731	53,05	4	0,29

Table 2: Honesty-screening responses in terms of gender

Gender	I would rather win than lose a game							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Male	31	2,25	558	40,49	39	2,83	1	0,07
Female	46	3,34	653	47,39	49	3,56	1	0,07
TOTAL	77	5,59	1 211	87,88	88	6,39	2	0,15

Table 2: Honesty-screening responses in terms of gender (continued)

Gender	I have never told a lie, not even a tiny one							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Male	64	4,64	139	10,09	425	30,84	1	0,07
Female	56	4,06	207	15,02	484	35,12	2	0,15
TOTAL	120	8,71	346	25,11	909	65,97	3	0,22

Gender	I do not like everyone I know							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Male	62	4,50	233	16,91	333	24,17	1	0,07
Female	48	3,48	345	25,04	354	25,69	2	0,15
TOTAL	110	7,98	578	41,94	687	49,85	3	0,22

Gender	At times I have felt like swearing							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Male	67	4,86	335	24,31	226	16,40	1	0,07
Female	63	4,57	433	31,42	249	18,07	4	0,29
TOTAL	130	9,43	768	55,73	475	34,47	5	0,36

Gender	I would probably get into a movie without ...							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Male	82	5,95	229	16,62	316	22,93	2	0,15
Female	70	5,08	262	19,01	415	30,12	2	0,15
TOTAL	152	11,03	491	35,63	731	53,05	4	0,29

Table 3: Honesty-screening responses in terms of age

Age	I would rather win than lose a game							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
10 – 13 years	22	1,60	389	28,23	24	1,74	–	–
14 – 16 years	21	1,52	321	23,29	18	1,31	–	–
17 years and older	34	2,47	501	36,36	46	3,34	2	0,15
TOTAL	77	5,59	1 211	87,88	88	6,39	2	0,15

Age	I have never told a lie, not even a tiny one							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
10-13 years	28	2,03	125	9,07	282	20,46	–	–
14-16 years	33	2,39	93	6,75	234	16,98	–	–
17 years and older	59	4,28	128	9,29	393	28,52	3	0,22
TOTAL	120	8,71	346	25,11	909	65,97	3	0,22

Age	I do not like everyone I know							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
10-13 years	36	2,61	178	12,92	221	16,04	–	–
14-16 years	24	1,74	152	11,03	184	13,35	–	–
17 years and older	50	3,63	248	18,00	282	20,46	3	0,22
TOTAL	110	7,98	578	41,94	687	49,85	3	0,22

Table 3: Honesty-screening responses in terms of age (continued)

Age	At times I have felt like swearing							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
10-13 years	38	2,76	237	17,20	160	11,61	—	—
14-16 years	41	2,98	199	14,44	119	8,64	1	0,07
17 years and older	51	3,70	332	24,09	196	14,22	4	0,29
TOTAL	130	9,43	768	55,73	475	34,47	5	0,36

Age	I would probably get into a move without ...							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
10-13 years	50	3,63	154	11,18	231	16,76	—	—
14-16 years	39	2,83	125	9,07	196	14,22	—	—
17 years and older	63	4,57	212	15,38	304	22,06	4	0,29
TOTAL	152	11,03	491	35,63	731	53,05	4	0,29

Table 4: Honesty-screening responses in terms of church attendance

Church attendance	I would rather win than lose a game							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Never	23	1,67	217	15,75	24	1,74	—	—
Weekly	25	1,81	563	40,86	37	2,69	—	—
Monthly	8	0,58	279	20,25	19	1,38	1	0,07
1-4 times a year	21	1,52	152	11,03	8	0,58	1	0,07
TOTAL	77	5,59	1 211	87,88	88	6,39	2	0,15

Table 4: Honesty-screening responses in terms of church attendance (continued)

Church attendance	I have never told a lied, not even a tiny one							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Never	26	1,89	60	4,35	178	12,92	–	–
Weekly	62	4,50	172	12,48	390	28,30	1	0,07
Monthly	21	1,52	66	4,79	219	15,89	1	0,07
1-4 times a year	11	0,80	48	3,48	122	8,85	1	0,07
TOTAL	120	8,71	346	25,11	909	65,97	3	0,22

Church attendance	I do not like everyone I know							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Never	26	1,89	108	7,84	130	9,43	–	–
Weekly	50	3,63	244	17,71	330	23,95	1	0,07
Monthly	20	1,45	143	10,38	143	10,38	1	0,07
1-4 times a year	14	1,02	83	6,02	84	6,10	1	0,07
TOTAL	110	7,98	578	41,94	687	49,85	3	0,22

Church attendance	At times I have felt like swearing							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Never	23	1,67	138	10,01	103	7,47	–	–
Weekly	61	4,43	346	25,11	215	15,60	3	0,22
Monthly	20	1,45	184	13,35	102	7,40	1	0,07
1-4 times a year	26	1,89	100	7,26	55	3,99	1	0,07
TOTAL	130	9,43	768	55,73	475	34,47	5	0,36

Table 4: Honesty-screening responses in terms of church attendance (continued)

Church attendance	I would probably get into a move without ..							
	Uncertain		True		False		No response	
	N	%	N	%	N	%	N	%
Never	35	2,54	89	6,46	139	10,09	1	0,07
Weekly	60	4,35	212	15,38	352	25,54	1	0,07
Monthly	32	2,32	120	8,71	154	11,18	1	0,07
1-4 times a year	25	1,81	70	5,08	86	6,24	1	0,07
TOTAL	152	11,03	491	35,63	731	53,05	4	0,29

Table 5: Drinking status of 10-21 year olds: Black communities in the RSA (1994)

Drinking status	Urban* (%)**		Rural * (%)	
	Male	Female	Male	Female
Abstainers	49,1	59,1	52,8	70,7
Former drinkers	10,6	8,6	8,0	6,3
Current drinkers	40,4	32,4	39,2	23,0
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	379	479	250	270

---

* In this and subsequent tables:
Urban areas include metropolitan centres and urbanized towns, excluding the former self-governing states and the TBVC states.
Rural areas include the former TBVC states and self-governing states.

** In this and subsequent tables:
Percentages do not necessarily total 100,0 but vary between 99,9 and 100,1.

Table 6: Drinking status of blacks in the RSA and the self-governing states (14 years and older) (1990), as well as in Gauteng (18-64 years old) (1990, 1985, 1982)

Drinking status	**RSA %**						**Self-governing states (%)**		**Gauteng (%)**					
	1990						**1990**		**1990**		**1985**		**1982**	
	Metros		**Towns**		**Squatters**									
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Abstainers and former drinkers	20	39	23	51	20	34	37	72	22	42	38	71	46	78
Current drinkers	80	61	77	49	80	66	63	28	78	58	62	29	54	22

Table 7: Type of alcoholic beverages consumed by 10-21 years olds: Black communities in the RSA — current drinkers (1994)

Alcoholic beverages	Urban* (%)		Rural * (%)	
	Male	**Female**	**Male**	**Female**
Ordinary beer	73,9	45,8	76,5	33,9
Home-made liquor	28,1	28,4	37,8	27,4
Cider	32,7	42,6	34,7	43,6
Wine	35,3	44,5	41,8	61,3
Distilled spirits	42,5	18,1	43,9	9,7
TOTAL (N)	153	155	98	62

---

* Percentages do not add up to 100,0 as respondents were required to respond to each category instead of choosing between categories.

Table 8: Type of alcoholic beverages consumed by blacks in the RSA and the self-governing states (14 years and older) (1990), as well as in Gauteng (18 – 64 years old) – current drinkers (1990, 1985, 1982)

Alcoholic beverages	RSA (%)						Self-governing states (%)		Gauteng (%)					
	1990						1990		1990		1985		1982	
	Metros		Towns		Squatters		Male	Female	Male	Female	Male	Female	Male	Female
	Male	Female	Male	Female	Male	Female								
European beer	71	39	80	50	75	40	82	45	73	39	89	64	92	77
Sorghum beer	13	10	21	13	16	9	22	12	18	..*	32	32	**	**
Sorghum-based home-made liquor	46	32	46	50	57	58	38	30	41	30	**	**	**	**
Wine	38	50	42	49	36	41	46	73	38	51	47	60	36	57
Distilled spirits	43	14	47	25	53	26	40	13	38	..	32	8	48	17

* Percentages for an N of less than 24 were not computed.

** Data were not accumulated.

Table 9: Drinking frequency (per alcoholic beverage) of 10-21 years olds: Black communities in the RSA — current drinkers (1994)

Frequency	Urban (%)		Rural (%)	
	Male	**Female**	**Male**	**Female**
Ordinary beer				
Less than once a week	55,8	64,8	30,7	57,1
At least once a week	44,2	35,2	69,3	42,9
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	113	71	75	21
Cider				
Less than once a week	67,3	67,2	44,1	75,0
At least once a week	32,7	32,8	55,9	25,0
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	52	67	34	27
Home-made liquor				
Less than once a week	90,7	95,5	64,9	82,4
At least once a week	9,3	4,6	35,1	17,6
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	43	44	37	17
Wine				
Less than once a week	66,7	77,5	54,8	71,1
At least once a week	33,3	22,5	45,2	28,9
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	54	71	42	38
Distilled spirits				
Less than once a week	54,6	50,0	51,2	..*
At least once a week	45,5	50,0	48,8	..
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	60	28	43	6

---

* Percentages for an N of less than 20 were not computed.

Table 10: Drinking frequency of blacks in the RSA and the self-governing states (14 years and older) (1990), as well as in Gauteng (18-64 years old) — current drinkers (1990, 1985, 1982)

Frequency	RSA %						Self – governing states (%)		Gauteng (%)					
	1990						1990		1990		1985		1982	
	Metros		Towns		Squatters									
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
European beer														
Less than once a week	21	29	14	25	15	26	43	68	22	26	37	43	15	50
At least once a week	79	71	87	75	85	74	57	32	78	74	63	57	85	50
Sorghum beer														
Less than once a week	23	55	31	..**	30	..	59	77	26	45	*	*	*	*
At least once a week	77	46	69	..	70	..	41	23	74	55	*	*	*	*
Sorghum-based home-made liquor														
Less than once a week	61	78	64	70	68	69	82	87	59	78	*	*	*	*
At least once a week	40	22	36	30	32	31	18	13	41	22	*	*	*	*
Non-sorghum-based home-made liquor														
Less than a week	68	58	..	..	65	60	78	78	55	64	*	*	*	*
At least once a week	32	42	..	..	35	40	22	22	45	36	*	*	*	*
Wine														
Less than once a week	50	62	56	50	28	44	85	87	56	67	76	71	54	60
At least once a week	60	38	44	50	72	56	15	13	44	33	24	29	46	40
Distilled spirits														
Less than once a week	49	57	46	44	34	48	79	98	64	78	61	..	47	..
At least once a week	51	43	54	56	66	52	21	2	36	22	39	..	53	..

* Data were not accumulated

** Percentages for an N of less than 24 were not computed

Table 11: Annual quantity (litres)[*] consumed per alcoholic beverage by 10-21 year olds: Black communities in the RSA — current drinkers (1994)

Quantity (litres)	Urban (%)		Rural (%)	
	Male	**Female**	**Male**	**Female**
Ordinary beer				
Less than 26	86,7	90,1	78,7	95,2
26 and above	13,3	9,9	21,3	4,8
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	113	71	75	21
Cider				
Less than 26	92,3	97,0	97,1	88,9
26 and above	7,7	3,0	2,9	11,1
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	52	67	34	27
Wine				
Less than 26	98,2	94,4	95,2	97,4
26 and above	1,9	5,6	4,8	2,6
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	54	71	42	38
Distilled spirits				
Less than 26	100,0	100,0	97,7	100,0
26 and above	—	—	2,3	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	66	28	43	6

---

[*] Annual quantity of consumption was calculated in terms of the KAT formula (Rocha-Silva, 1987).

Table 12: Annual quantity (litres)[*] consumed by blacks in the RSA and the self-governing states (14 years and older) by type of beverage consumed — current drinkers (1990)

Quantity (litres)	**RSA (%)**						**Self-governing states (%)**	
	Metros		**Towns**		**Squatters**			
	Male	Female	Male	Female	Male	Female	Male	Female
European beer								
Less than 26	8,7	19,5	6,3	13,2	7,9	13,2	20,1	43,3
26 and above	91,3	80,5	93,7	86,8	92,1	86,8	79,9	56,7
Sorghum beer								
Less than 26	12,0	..[**]	10,3	..	23,1	..	37,4	0,0
26 and above	88,0	..	89,7	..	76,9	..	62,6	
Sorghum-based home-made liquor								
Less than 26	45,7	59,7	39,1	42,6	39,2	46,9	57,6	62,8
26 and above	54,3	40,3	60,9	57,4	60,8	53,2	42,4	37,2
Non-sorghum-based home-made liquor								
Less than 26	50,0	37,5	..	..	32,3	20,8	59,7	59,2
26 and above	50,0	62,5	..	..	67,7	79,2	40,3	40,8
Wine								
Less than 26	46,6	62,3	45,8	50,0	22,0	46,2	74,9	81,1
26 and above	53,4	37,7	54,2	50,0	78,0	53,9	25,1	18,9
Distilled spirits								
Less than 26	80,5	86,2	64,6	77,8	77,8	81,3	88,8	100,0
26 and above	19,5	13,8	35,4	22,2	22,2	18,8	13,2	—

---

[*] Annual quantity of consumption was calculated in terms of the KAT formula (Rocha-Silva, 1987).

[**] Percentages for an N of less than 24 were not computed.

Table 13: Total annual quantity (litres) of absolute alcohol[*] consumed by 10-21 years olds: Black communities in the RSA — current drinkers[**] (1994)

Quantity (litres)	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Less than 25,6	81,5	90,5	68,5	86,5
25,6[***] - 36,4	7,3	3,4	11,9	5,8
36,5[•] and more	11,3	6,1	19,6	7,7
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	151	148	92	52

---

[*] Total annual absolute alcohol intake was calculated by expressing the total annual quantity (litres), respectively, of ordinary beer, cider, wine, sorghum beer and distilled spirits that a drinker consumes in terms of absolute alcohol. It is assumed that ordinary beer contains 6,0 per cent absolute alcohol, cider 5,0 per cent, wine 12,0 per cent, sorghum beer 3,0 per cent and distilled spirits 43,0 per cent (Cooper *et al.*, 1979; personal communication with representatives of the Department of Agriculture and the Council for Scientific and Industrial Research).

[**] Does not include the quantity of home-made liquor consumed, as it is difficult to estimate the average absolute alcohol content of such alcoholic beverages.

[***] 25,6 litres AA per year = 7 cl AA on average per day.

[•] 36,5 litres AA per year = 10 cl AA on average per day (i.e. 9,3 tots of distilled spirits or 6,7 standard glasses of wine or 4,9 small (340 ml) bottles or ordinary beer or 3,3 litres of sorghum beer or 5,9 (340 ml) cans/bottles of cider).

Table 14: Total annual quantity (litres) of absolute alcohol[*] consumed by blacks in the RSA and the self-governing states — current drinkers (1990)

Quantity (litres)	**RSA (%)**						**Self-governing states (%)**	
	Metros		**Towns**		**Squatters**		Male	Female
	Male	Female	Male	Female	Male	Female		
Less than 36,5	63,4	81,5	66,4	82,7	62,8	75,2	83,8	95,0
36,5[**] - 49,9	15,2	3,7	9,6	4,0	12,2	8,0	4,8	1,3
50,0[***] and more	21,3	14,8	24,0	13,3	25,0	16,8	11,4	3,7

---

[*] Does not include the consumption of home-made liquor, as it is difficult to estimate the absolute alcohol content of these beverages.

[**] 36,5 litres AA per year = an average of 10 cl AA a day (9,3 tots of distilled spirits or 6,7 glasses of wine or 4,9 small (340 ml) bottles of beer or 0,42 of a small bottle (250 ml) of methylated spirits).

[***] 50,0 litres AA per year = an average of 13,7 cl a day.

Table 15: Use of substances other than alcohol by 10-21 year olds: Black communities in the RSA — current users (1994) — 'Yes' responses

Substances	Urban (%)*		Rural (%)*	
	Male	**Female**	**Male**	**Female**
Tobacco/cigarettes	22,2	4,6	24,4	..
Dagga	5,5	..	..	..
White pipe (mixture of dagga and mandrax)	..	—	—	—
Solvents	..	..	..	..
Pain-relievers bought over the counter (e.g. Grandpa, Syndol)	73,4	74,9	64,4	76,3
Over-the-counter medicine (e.g. cough/allergy medicine, Lennon's products)	54,9	59,1	52,8	56,7
Non-prescriptive sedatives	10,6	5,9	..	..
Non-prescriptive tranquilizers	8,2	5,0	..	..
Non-prescriptive stimulants	8,2	4,8	..	..
LSD	..	..	..	..
Mandrax	..	..	..	..
Cocaine	..	—	..	..
Heroin	..	..	..	..
Ecstasy	..	—	—	—
Non-prescriptive narcotics (other than heroin) (e.g. morphine, opium, pethidine, Welconal)	..	..	..	..
Steroids	..	..	..	..
TOTAL (N)	379	479	250	270

---

* Percentages do not add up to 100,0 as the respondents were required to respond to each response category.

Table 16: Use of substances other than alcohol, tobacco, dagga, white pipe (mixture of dagga and mandrax): 10-21 year olds in black communities in the RSA (1994) — 'Yes' responses to set questions:

(a) 'Do you know someone in your neighbourhood who uses ...?'
(b) 'Have *you ever* used ...?'
(c) 'Have *you* used ... during the *past 12 months*?'

Substances	**(a) Neighbours' Use (%)***	**(b) Personal Lifetime Use (%)***	**(c) Personal Current Use (%)***
Pain-relievers bought over the counter (e.g. Grandpa, Syndol)	78,9	88,9	72,9
Over-the-counter medicine (e.g. cough/allergy medicine, Lennon's products)	70,5	76,8	56,3
Non-prescriptive sedatives	12,8	7,2	7,2
Non-prescriptive tranquilizers	6,7	5,7	5,7
Non-prescriptive stimulants	9,4	5,5	5,5
LSD	2,9	1,9	1,5
Mandrax	6,6	1,7	1,7
Cocaine	3,8	0,9	0,8
Heroin	0,9	0,9	0,9
Ecstasy	0,2	0,1	—
Non-prescriptive narcotics (other than heroin) (e.g. morphine, opium, pethidine, Welconal)	2,2	2,1	2,1
Steroids	2,9	2,0	2,9
TOTAL (N)	1 378	1 378	1 378

---

* Percentages do not add up to 100,0, as the respondents were required to respond to each response category instead of choosing between the relevant categories.

Table 17: Use of substances other than alcohol by blacks in the RSA (14 years and older) — current users (1990)

Users	RSA (%)					
	Metros		Towns		Squatters	
	Male	Female	Male	Female	Male	Female
Tobacco	59,3	11,9	60,6	16,4	72,0	20,2
Dagga	12,8	..	8,9	..	22,3	..
White pipe (mixture of dagga and mandrax)	..*	..	..	—	5,7	—
Solvents	..	..	..	..	..	..
Snuff	7,8	26,3	..	17,8	4,7	13,9
Pain-relievers bought over-the-counter (e.g. Grandpa, Syndol, etc.)	79,1	81,3	83,9	86,3	75,6	89,2
Over-the-counter medicines (e.g. cough/allergy medicines, Lennon's products)	57,7	58,8	64,2	53,7	53,4	67,5
Non-prescriptive anti-depressants	..	..	..	5,0	..	..
Non-prescriptive sedatives	4,2	4,3	..	4,6	5,3	4,2
Non-prescriptive tranquilizers	..	3,5	..	..	..	4,2
Non-prescriptive stimulants	..	3,5	..	..	..	..
Mandrax	..	—	..	—	..	..
LSD	7,9	..	17,8	8,7	..	5,6
Cocaine	5,9	..	17,2	10,5	6,2	7,3
Heroin	—	—	..	..	—	..
Non-prescriptive narcotics (other than heroin) (e.g. morphine, pethidine, Welconal)	5,9	3,5	10,0	12,4	..	8,4
TOTAL (N)	243	180	211	354	219	287

---

* Percentages for an N of less than 10 were not computed.

Table 18: Frequency (per substance) with which substances other than alcohol are used by 10-21 year olds: Black communities in the RSA — current users (1994)*

Frequency	Urban (%)		Rural (%)	
	Male	**Female**	**Male**	**Female**
Tobacco/cigarettes				
Less than once a week	14,6	31,8	4,9	45,5
At least once a week	85,4	68,2	95,1	54,6
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	82	22	61	11
Dagga				
Less than once a week	33,3	..**	..	..
At least once a week	66,7	..	..	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	21	2	13	2
Pain-relievers bought over the counter				
Less than once a week	74,4	75,0	70,2	70,4
At least once a week	25,6	25,0	28,9	29,6
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	207	280	131	152
Over-the-counter medicine				
Less than once a week	85,2	..	..	..
At least once a week	14,8	..	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	27	17	12	5

---

* Data relate to substances other than alcohol that were used by at least 20 respondents who were able to recall their frequency of usage.

** Percentage for an N of less than 20 were not computed.

Table 19: Frequency with which substances[*] other than alcohol are used by blacks in the RSA (14 years and older) — current users (1990)

Frequency	RSA (%)					
	Metros		**Town**		**Squatters**	
	Male	Female	Male	Female	Male	Female
Tobacco						
At least once a week	97,9	97,6	100,0	94,4	96,7	93,1
Less than once a week	2,1	2,4	—	5,6	3,3	6,9
Dagga						
At least once a week	87,1	..[**]	25,0	..	83,0	..
Less than once a week	12,9	..	75,0	..	17,0	..
Snuff						
At least once a week	31,6	73,1	..	89,7	40,0	70,0
Less than once a week	68,4	26,9	..	10,3	60,0	30,0
Pain-relievers bought over-the-counter						
At least once a week	10,3	16,8	11,8	17,0	8,9	21,5
Less than once a week	89,7	83,2	88,2	83,0	91,1	78,5
Over-the-counter medicines (e.g. cough/allergy medicines, Lennon's products)						
At least once a week	9,6	9,3	15,0	14,9	2,6	9,4
Less than once a week	90,4	90,7	85,0	85,2	97,4	90,6
Non-prescriptive sedatives						
At least once a week	20,0	15,4	..	..	..	8,3
Less than once a week	80,0	84,6	..	..	..	91,7
LSD						
At least once a week	44,4	..	53,1	57,9	..	66,7
Less than once a week	55,6	..	46,9	42,1	..	33,3
Cocaine						
At least once a week	73,3	..	58,1	57,1	71,4	57,1
Less than once a week	26,7	..	41,9	42,9	28,6	42,9
Non-prescriptive narcotics other than heroin						
At least once a week	35,7	8,3	16,7	13,6	..	4,4
Less than once a week	64,3	91,7	83,3	86,4	..	95,7

---

[*] Only with regard to those substances used by at least 10 respondents.

[**] Percentages for an N of less than 10 were not computed.

Table 20: What current smokers smoke and the quantity of use among 10-21 year olds: Black communities in the RSA (1994)

Substance and quantity of use	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Substance				
Cigarettes	100,0	95,5	100,0	..
Cigars	—	—	—	—
Pipe	—	—	—	—
Chewable tobacco	—	4,6	—	—
All of the above	—	—	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	84	22	61	10
Quantity of cigarettes/pipes/cigars smoked				
Over 40 per day	—	—	—	—
21-40 per day	3,6	—	—	10,0
11-20 per day	9,5	13,6	4,9	—
5-10 per day	38,1	31,8	57,4	20,0
2-4 per day	34,5	31,8	34,4	30,0
1 per day or fewer	14,3	22,7	3,3	40,0
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	84	22	61	10

Table 21: First use of various substances by 10-21 year olds: Black communities in the RSA (1994)

First use of various substances	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Alcohol				
Age of onset:				
Less than 10 years	4,1	5,6	2,7	5,4
10-13 years	26,4	26,7	22,1	27,0
14-17 years	54,3	46,2	60,2	44,6
18 years and older	15,2	21,5	15,0	23,0
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	197	195	113	74
Manner obtained:				
Through relatives	20,3	31,4	19,4	21,9
Through friends	51,6	46,8	40,7	57,5
Self	27,1	21,3	36,1	17,8
Another way	1,0	0,5	3,7	2,7
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	192	188	108	73
Experience:				
Nice	40,5	44,9	52,2	52,0
Not nice	39,0	41,3	38,1	40,0
In between	15,9	11,7	8,0	2,7
Can't tell	4,6	2,0	1,8	5,3
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	195	196	113	75
Wanted to drink again:				
Yes	42,3	32,7	65,5	44,0
No	47,4	59,2	28,3	50,7
Can't tell	10,3	8,2	6,2	5,3
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	194	196	113	75
Reason for first drink:				
To see what it was like	39,6	41,5	38,9	48,0
On a date	3,1	6,2	4,4	8,0
A friend insisted that I taste it	13,2	20,0	19,5	8,0
I was interested because it was forbidden	6,6	2,6	6,2	1,3
I was tricked into thinking it was something else	4,6	4,1	7,1	5,3
I thought it would be fun	30,0	24,6	23,9	26,7
Other	3,0	1,0	—	2,7
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	197	195	113	75

Table 21: First use of various substances by 10-21 year olds: Black communities in the RSA (1994) (continued)

First use of various substances	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Cigarettes/tobacco				
Age of onset:				
Less than 10 years	5,2	—	3,0	—
10-13 years	24,2	7,7	15,2	..
14-17 years	53,5	76,9	60,6	..
18 years and older	17,2	15,4	21,2	..
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	99	26	66	10
Manner obtained:				
Through relatives	6,6	6,9	5,4	..
Through friends	63,2	55,2	66,2	..
Self	29,3	34,5	28,4	—
Another way	0,9	3,5	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	106	29	74	12
Experience:				
Nice	32,1	41,4	51,4	..
Not nice	44,3	48,3	37,8	..
In between	14,2	6,9	6,8	..
Can't tell	9,4	3,5	4,1	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	106	29	74	12
Wanted to smoke again:				
Yes	58,5	31,0	70,3	..
No	31,1	65,5	25,7	..
Can't tell	10,4	3,5	4,1	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	106	29	74	12
First smoke:				
Before first drink	52,8	34,5	46,0	..
After first drink	30,2	41,4	33,8	..
Can't tell	17,0	24,1	20,3	..
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	106	29	74	12

Table 21: First use of various substances by 10-21 year olds: Black communities in the RSA (1994) (continued)

First use of various substances	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Reason for first smoke:				
To see what it was like	54,7	58,6	33,8	..
It was on a dare	3,8	6,9	1,4	..
I was on a date	1,9	3,5	—	—
A friend insisted that I try it	20,8	6,9	28,4	..
I was interested because it is forbidden	4,7	—	2,7	—
I thought it would be fun	12,3	24,1	31,1	..
Other	1,9	—	2,7	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	106	29	74	12
Dagga				
Age of onset:				
Less than 10 years	—	—	..	—
10-13 years	4,2	..	—	—
14-17 years	54,2	..	..	..
18 years and older	41,7	..	..	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	24	7	18	1
Solvents				
Age of onset:				
Less than 10 years	20,7	21,7	17,2	..
10-13 years	51,7	43,5	58,6	..
14-17 years	24,1	21,7	20,7	..
18 years and older	3,5	13,0	3,5	..
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	29	23	29	17
Manner obtained:				
Through relatives	6,9	26,1	—	..
Through friends	65,5	65,2	83,3	..
Self	27,6	8,7	16,7	..
Another way	—	—	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	29	23	30	16

Table 21: First use of various substances by 10-21 year olds: Black communities in the RSA (1994) (continued)

First use of various substances	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Experience:				
Nice	31,0	52,2	36,7	..
Not nice	62,1	39,1	50,0	..
Can't tell	6,9	8,7	13,3	..
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	29	23	30	16
Wanted to sniff again:				
Yes	6,9	26,1	30,0	..
No	89,7	69,6	60,0	..
Can't tell	3,5	4,4	10,0	..
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	29	23	30	16
Reason for first sniff:				
To see what it was like	51,7	34,8	30,0	..
It was a dare	13,8	17,4	6,7	—
A friend/another person insisted that I try	27,6	21,7	26,7	..
I thought it would be fun	6,9	21,7	36,7	..
Other	—	4,4	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	29	23	30	16

Table 22: Reasons for not using alcohol/cigarettes/tobacco given by 10-21 year olds: Black communities in the RSA (1994) — current users

Reasons	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Reasons for not drinking[*]				
Dislike the taste	65,0	70,2	65,7	69,6
It is bad for you	84,9	86,9	83,8	83,9
It is against my religious beliefs	67,4	74,8	72,1	78,8
It makes people behave badly	88,8	92,2	85,3	85,5
My parents/guardians/spouse disapprove of my drinking	78,8	86,2	75,0	75,7
I want to be fit	62,6	62,8	48,5	60,1
My friends are against it	62,6	63,8	51,5	63,7
I am too young	90,5	87,9	78,7	76,6
It becomes a bad habit	88,8	89,7	83,8	90,2
TOTAL (N)	179	282	136	193
Main reason for not drinking				
Bad habit, destroys future, misleads you, diminishes your dignity, makes you do what you don't want to	21,5	30,0	20,0	22,2
Don't want to be a drunkard/alcoholic	1,7	1,5	2,3	1,6
Happy as I am, not interested in drinking, don't want to drink, have no reason to drink	0,6	1,9	0,8	3,2
Not my lifestyle	19,2	18,9	18,5	22,2
Not good for my health	14,0	8,1	10,8	9,7
Afraid of harassment when under the influence, dangerous to drink	—	—	0,8	0,5
Against my belief to drink, I attend church	1,7	3,0	3,9	9,2
Too young to drink	30,8	22,6	35,4	21,2
Don't like the taste, tastes bitter	1,2	1,9	1,5	2,2
Because I'm still at school, I have to concentrate on my studies	1,2	1,5	0,8	1,1
Afraid of my parents, my mother does not want me to drink	1,7	4,8	1,5	4,3
The smell of alcohol is bad	1,2	0,4	—	—
Not good for girls to drink	—	2,1	—	1,6
A waste of money to drink	0,6	0,4	2,3	—
Can't tell	4,7	3,0	1,5	1,1
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	172	270	130	185

---

[*] Percentages do not add up to 100,0, as respondents were required to respond to each category instead of choosing between categories.

Table 22: Reasons for not using alcohol/cigarettes/tobacco given by 10-21 year olds: Black communities in the RSA (1994) — current users (continued)

Reasons	Urban (%)		Rural (%)	
	Male	**Female**	**Male**	**Female**
Reasons for not smoking*				
Dislike the taste	67,5	73,3	67,8	67,3
It is bad for you	86,6	89,8	88,5	83,9
It costs too much	73,1	70,7	66,1	63,8
Once you start, you can't stop the habit	78,7	75,1	71,3	72,1
My parents/guardians/spouse disapprove	75,4	79,3	69,5	70,1
My friends are against it	60,8	62,4	52,3	56,7
Do not want to smoke	94,0	94,4	92,5	90,9
It becomes a bad habit	89,2	89,1	83,3	85,0
Bad for my health	91,4	89,5	83,9	86,2
TOTAL (N)	268	450	174	254
Main reason for not smoking:				
Harms lungs, not good for my health, don't want to get TB/cancer/asthma, bad for me, bad habit	47,9	53,9	43,4	47,4
I dislike/hate it	16,5	10,7	18,1	19,7
Don't have the desire/interest	3,5	6,3	14,5	10,4
I'm too young, not ready	12,3	4,4	7,2	3,2
I'm a girl, prostitutes smoke	—	3,3	—	3,6
Smoking is expensive	2,3	2,1	5,4	2,8
Not easy to stop, once can become dependent	0,8	0,9	0,6	0,8
Makes one's breath smell	2,7	6,1	2,4	4,8
Against my religious beliefs	0,8	1,4	1,2	1,2
Dislike the taste	1,2	3,0	1,8	0,8
My parents hate cigarettes	1,5	1,4	3,0	2,8
Can't smoke if I don't drink	—	0,2	—	—
I only like alcohol	—	0,2	—	—
Can't tell	10,6	6,2	2,4	2,4
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	261	429	166	249

Table 23: Reasons for drinking and using other substances given by 10-21 year olds: Black communities in the RSA (1994) — current users

Reasons	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Reasons for drinking*				
Personal/social/religious custom:				
My parents do it	11,2	18,5	13,7	19,0
I'm used to it	22,4	28,5	44,2	38,0
For the spirits of my ancestors	14,0	17,9	30,5	24,1
My friends drink	44,1	41,1	51,6	43,1
Part of a meal:				
It is food	15,4	13,3	22,1	34,5
Mood-changing:				
To get drunk/come nice	55,9	44,4	73,7	65,5
Coping with personal/social/interpersonal situations:				
To give myself courage/confidence	37,1	34,7	62,1	53,5
To help me talk to members of the opposite sex	25,1	12,6	40,0	22,4
So that my friends won't think I'm scared	37,8	25,8	34,7	43,1
Because I don't have a job	9,8	13,3	13,7	6,9
Enjoyment:				
I enjoy it	62,2	55,0	79,0	63,8
I like the taste	49,7	60,0	66,3	58,6
Social value:				
Not to be the odd one out in a group	38,5	42,0	50,5	50,0
It's grown—up	21,7	21,2	27,4	19,0
Curiosity/experimentation:				
To find out what it is like	65	55,6	74,7	72,4
TOTAL (N)	143	151	95	58
Main reasons for drinking				
Enjoyment:				
For fun, entertainment, enjoyment	39,1	37,6	59,3	49,0
I like the taste	2,6	6,7	2,3	10,2
To celebrate	1,3	1,3	—	8,2
Personal/social/religious custom:				
My tradition, my parents insist	5,8	10,6	2,3	2,0
Social value:				
To socialize, my friends drink	22,4	17,5	15,1	12,2

---

* Percentages do not add up to 100,0, as respondents were required to respond to each category instead of choosing between categories.

Table 23: Reasons for drinking and using other substances given by 10-21 year olds: Black communities in the RSA (1994) — current users (continued)

Reasons	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Health improvement:				
It is healthy	0,6	—	—	—
Mood-changing:				
To get drunk	2,6	1,3	—	2,0
I want to be free to do what I want to do	—	—	3,5	—
Coping with personal/social/interpersonal situations:				
To keep my busy	2,6	—	—	—
To give me courage/strength	0,6	0,7	—	—
To forget about suffering	7,7	9,4	11,6	12,2
To overcome loneliness	0,6	—	—	—
To get on with members of the opposite sex	0,6	—	2,3	—
Can't tell	13,5	14,8	3,5	4,1
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	156	149	86	49
Reasons for using cigarettes/tobacco*				
Personal/social/religious custom:				
My parents do	3,6	22,7	13,1	—
I'm used to it	54,0	72,3	73,3	40,0
It's fashionable/'in'	28,6	36,4	41,0	40,0
It's grown-up	26,2	27,3	32,8	50,0
My friends do it	51,2	45,5	59,0	50,0
Mood-changing:				
To get alright/okay	58,3	68,2	80,3	80,0
To calm my nerves/relax	64,3	68,2	70,5	70,0
Coping with personal/social/interpersonal situations:				
To give myself courage/confidence	45,2	59,1	59,0	80,0
To help me talk to members of the opposite sex more easily	8,3	18,2	29,5	25,0
So that my friends won't think I'm scared	34,5	22,7	32,8	25,0
To help me mix more easily with people	29,8	40,9	50,8	50,0
Enjoyment:				
I enjoy it	76,2	77,3	80,3	80,0
Social value				
Not to be the odd one out	35,7	45,5	37,7	80,0
Health improvement:				
To lose weight	8,3	22,7	16,4	—
TOTAL (N)	84	22	61	10

Table 23: Reasons for drinking and using other substances given by 10-21 year olds: Black communities in the RSA (1994) — current users (continued)

Reasons	Urban (%)		Rural (%)	
	Male	Female	Male	Female
Main reason for using cigarettes/tobacco				
Enjoyment:				
To enjoy it	17,8	16,7	20,2	—
For fun	4,1	11,0	4,1	—
I like the taste	5,5	—	6,1	12,5
Personal/social/religious custom:				
My friends do	11,0	5,6	14,3	—
Used to it	4,1	—	8,2	—
It's grown up	1,4	—	—	—
Part of my culture	1,4	11,1	—	12,5
Coping with personal/social/interpersonal situations:				
Keeps worries about girls/boys away	—	—	2,0	12,5
To keep myself busy	5,5	5,6	2,4	—
I need it	2,7	—	2,0	—
Mood-changing:				
Calms my nerves	26,0	22,2	14,3	37,5
To get alright	4,1	—	2,0	12,5
Helps me to concentrate	2,7	5,6	8,2	—
Health improvement:				
To lose weight/improve health	5,5	5,6	2,0	—
Can't tell	8,2	16,7	14,3	12,5
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	73	18	49	8
Reasons for using solvents*				
Personal/social custom:				
Used to it	20,0	50,0	83,3	66,7
My friends do it	40,0	50,0	100,0	100,0
Enjoyment:				
It is fun	40,0	80,0	100,0	100,0
Mood-changing:				
Makes me feel alright/okay	—	50,0	83,3	66,7
Makes me feel drunk	20,0	50,0	66,7	100,0
Coping with personal/social/interpersonal situations:				
Takes away hunger	20,0	—	16,7	33,3
Takes away the cold winter	—	20,0	50,0	33,3
TOTAL (N)	5	10	6	3

BEST COPY AVAILABLE

Table 23: Reasons for drinking and using other substances given by 10-21 year olds: Black communities in the RSA (1994) — current users (continued)

Reasons	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Main reasons for using solvents				
Personal/social custom:				
To join my friends	40,0	—	14,3	50,0
Enjoyment:				
To have fun	—	10,0	28,6	—
Want to sniff	20,0	—	14,3	—
Mood-changing:				
To relieve tension	—	40,0	14,3	—
Coping with personal/social/interpersonal situations:				
To forget I'm poor	—	—	14,3	50,0
Health improvement:				
To clear my nose	—	10,0	—	—
Because its available	—	10,0	—	—
Can't tell	40,0	30,0	14,3	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	5	10	6	2
Use of substances other than alcohol/cigarettes/solvents — main reason				
Enjoyment:				
For fun/enjoyment	2,9	3,2	2,4	1,4
I like it	—	1,0	1,6	—
Health improvement:				
Gives me energy/stamina	53,7	58,0	66,1	68,7
Coping with personal/social/interpersonal situations:				
To overcome boredom/pass time	0,4	—	0,8	—
To feel brave	—	—	0,8	—
Mood-changing:				
Relieves tension/calms me	6,2	7,6	1,6	2,0
To get intoxicated/drunk	0,4	—	—	—
Can't tell	36,4	30,3	26,8	27,9
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	242	317	127	147

Table 24a: Reasons for drinking and drugging given by blacks in the RSA (14 years and older) — current users (1990)

Users	RSA (%)					
	Metros		Town		Squatters	
	Male	Female	Male	Female	Male	Female
Drinking*						
A personal/social/religious custom:						
It is traditional	42,6	31,1	30,2	44,8	48,7	61,4
Friends do it/expect it	19,5	18,1	21,7	18,4	34,8	20,9
Parents do it/expect it	..**	..	..	..	..	..
It is a habit	35,5	18,1	45,0	28,7	44,5	26,8
For the spirits of my forefathers	19,5	15,3	14,7	13,8	27,1	32,7
Spouse/partner does it	..	5,7	..	11,5	6,5	11,1
Part of meal:						
It is food	16,0	10,2	14,0	12,6	10,3	11,8
It improves digestion	9,5	5,7	14,7	..	..	..
Mood – changing:						
To feel happier	64,5	54,2	69,0	63,2	70,3	53,6
To relax	32,5	32,2	28,7	31,0	40,0	26,8
To feel better	26,6	20,9	32,6	32,2	33,6	32,7
Health improvement:						
It makes me healthy	21,9	13,6	20,2	..	21,9	19,0
To sleep	18,9	23,2	22.5	24,1	16,1	16,3
Coping with personal/social/inter-personal situations:						
To do my work	14,2	14,7	17,1	13,8	18,1	13,8
Because of unemployment	8,9	8,5	7,8	8,1	9,0	9,8
To forget my troubles	37,9	24,3	38,0	36,8	45,2	31,4
To overcome shyness	21,9	15,3	29,5	19,5	20,0	10,5
Because of loneliness	24,3	14,8	29,5	13,8	21,3	12,5
To be confident	17,8	16,4	17,8	11,5	24,5	16,3
Enjoyment:						
I enjoy it	74,0	60,3	80,5	52,9	87,1	64,7
It tastes nice	46,2	34,7	41,1	32,6	46,5	41,8

---

* Percentages do not add up to 100,0, as respondents were required to respond to each category instead of choosing between categories.

** Percentages for an N less than 24 were not computed.

Table 24a: Reasons for drinking and drugging given by blacks in the RSA (14 years and older) — current users (1990) (continued)

Users	RSA %					
	Metros		**Towns**		**Squatters**	
	Male	Female	Male	Female	Male	Female
Social value:						
To keep spouse/partner company	8,3	10,2	7,8	14,9	13,6	15,7
To enjoy parties/be sociable	52,1	39,2	53,5	43,7	48,7	37,3
Other	—	—	—	—	—	—
TOTAL (N)	243	354	180	219	211	287
Drugging*						
A personal/social/custom:						
Friends do it/expect it	6,8	4,1	8,8	..	12,4	6,5
Parents do it/expect it	4,4	6,1	..	5,5	..	5,4
It is a habit	30,9	15,7	29,6	18,2	26,6	15,3
Spouse/partner does it	..	..	..	..	..	6,5
Mood-changing:						
Gives me a kick/good trip	5,9	6,8	15,1	8,8	11,9	9,2
Want to feel good	55,3	57,5	54,1	58,0	52,3	62,5
Relaxing	21,8	29,3	30,2	39,2	27,7	27,6
Helps me to feel happier	22,3	23,1	25,2	33,7	29,4	25,3
Helps me to feel sociable	7,3	5,1	11,3	..	8,5	6,1
Health improvement:						
Fear withdrawal symptom	12,5	10,2	12,7	12,2	17,0	16,9
Gives energy	25,2	22,1	30,8	32,6	27,7	29,5
Helps me to sleep	25,7	28,6	34,6	39,2	30,5	29,5
Helps me to lose weight	3,9	4,8	..	..	..	3.8
Coping with personal/social/interpersonal situations						
Because of unemployment	4,4	..	..	6,6	..	5,4
Helps me to forget troubles	17,0	9,6	16,5	13,8	20,9	10,7
Helps me to overcome shyness	5,8	..	..	..	..	..
Helps me to overcome loneliness	9,7	5,1	8,8	..	9,0	..
Helps me to be more confident	10,7	9,5	16,4	10.5	15,3	10,7
Helps me to work	20,9	21,7	34,2	37,0	19,9	20,5
Enjoyment:						
I enjoy it	32,4	20,1	35,9	20,4	39,6	23,4
It tastes nice	20,8	11,9	23,9	16,0	24,9	18,0
Social value:						
To keep spouse/partner company	..	..	..	..	..	4,2
TOTAL (N)	243	354	180	219	211	287

Table 24b: Reasons for drinking and drugging given by blacks in the former self-governing states — current users (1990)

Reasons	Self – governing states (%)	
	Male	**Female**
Drinking*		
A personal/social/religious custom:		
It is traditional	23,6	28,6
It is customary at marriages and tribal ceremonies	25,0	26,4
Friends do so	15,1	16,1
Friends expect it	6,4	8,0
Parents do it	1,9	1,6
Parents expect it	1,4	1,0
I am used to it	18,2	11,3
For the spirits of my forefathers	14,4	20,9
Part of a meal:		
It is food	13,9	11,9
To stimulate appetite	13,0	12,5
To improve digestion	5,2	5,1
Mood-changing:		
To feel happier	62,3	55,0
To relax	27,4	14,8
To feel better	24,8	13,5
Health improvement:		
It is nutritious	9,0	7,7
It is healthy	17,0	10,9
To sleep	17,5	16,1
Coping with personal/social/interpersonal situations:		
Because of unemployment	3,3	4,8
For courage	7,8	7,1
To forget my troubles	19,3	20,6
To overcome shyness	17,0	12,9
Because of loneliness	20,0	12,2
To feel confident	5,7	5,8
Enjoyment:		
I enjoy it	77,4	65,0
Tastes nice	42,5	39.2
Social value:		
To enjoy parties	47,2	43,4
To be sociable	35,6	24,4
Other	1,9	8,4
TOTAL (N)	424	311

---

* Percentages do not add up to 100,0, as respondents were required to respond to each category instead of choosing between categories.

Table 24b: Reasons for drinking and drugging given by blacks in the former self-governing states — current users (1990) (continued)

Reasons	Self – governing states (%)	
	Male	**Female**
Drugging*		
A personal/social custom:		
Friends do it	4,3	1,4
Friends expect it	3,4	1,3
Parents do so	3,2	2,7
I'm used to it	19,3	7,2
Mood-changing:		
It gives me a feeling of euphoria	4,6	3,4
It gives me a kick	5,5	3,8
I want to feel good	60,3	65,7
It is relaxing	25,7	21,0
It makes me happy	25,7	20,1
Health improvement:		
I fear withdrawal symptoms	6,6	5,6
Gives me energy	17,9	15,4
Helps me to sleep	27,0	34,4
Helps me to lose weight	2,0	0,8
Coping with personal/social/inter-personal situations:		
Because of unemployment	1,2	0,6
Gives me courage	10,5	6,7
Helps to forget troubles	8,2	4,5
Helps me to overcome shyness	2,8	0,8
Helps me to overcome loneliness	4,1	1,7
Helps me to be more confident	5,7	2,0
Helps me to work	28,4	23,8
Enjoyment:		
I enjoy it	33,2	10,3
It tastes nice	13,3	6,6
Social value:		
Helps me to be sociable	8,7	2,3
TOTAL (N)	564	972

Table 25 Context within which alcohol and other drugs are used by 10-21 years olds: Black communities in the RSA (1994) — current users

Context	Urban (%)		Rural (%)	
	Male	Female	Male	Female
Alcohol				
Usually drink in company/in company and alone	96,4	92,2	96,7	98,3
Usually drink alone	3,6	2,8	3,3	1,7
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	141	145	92	58
Persons with whom drinkers mostly drink:				
Spouse/sexual partner	1,5	3,0	3,3	7,7
Date	1,5	3,0	2,2	5,8
Friends: Older	17.5	14,9	13,0	9,6
Same age/younger	73,7	67,9	75,0	67,3
Relatives	1,5	1,5	1,1	1,9
Others	4,4	9,7	5,4	7,7
TOTAL (%)	100.0	100.0	100,.0	100,0
TOTAL (N)	137	134	92	52
Place where drinkers mostly drink:				
At school	—	1,5	—	3,6
At work	0.7	—	—	1,8
At home/place where I live:				
when parents/guardians are in/out	19,0	27,4	12,2	26,8
when parents/guardians are out	14,8	14,8	12,2	10,7
At home of relatives (*where I bring my own drink or get it for free*)	3,5	9,6	3,3	7,1
At home of fiends (*where I bring my own drink or get it for free*)	14,8	22,2	22,2	19,6
At a shebeen/tavern/home where I have to pay for my drink	25,4	14,1	25,6	14,3
At a bottle-store	4,9	2,2	17,8	3,6
At a club/discothèque	12,0	4,4	4,4	5,4
Another place	4,9	3,7	2,2	7,2
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	142	135	90	56
Time of day drinkers take their first drink of the day:				
First thing in the morning	5,0	7,3	9,7	5,3
Lunch-time/between 12 and 2 pm	21,3	19,0	30,1	22,8
After lunch but before the evening meal	20,6	21,9	25,8	24,6
With/after evening meal	14,9	21,2	17,2	22,8
At night	38,3	30,7	17,2	24,6
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	141	137	93	57

Table 25 Context within which alcohol and other drugs are used by 10-21 years olds: Black communities in the RSA (1994) — current users (continued)

Context	Urban (%)		Rural (%)	
	Male	Female	Male	Female
Cigarettes/tobacco				
Usually smoke in company/in company and alone	83,3	72,7	90,0	100,0
Usually smoke alone	16,7	27,3	10,0	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	84	22	60	10
Persons with whom smokers mostly smoke:				
Spouse/sexual partner	—	—	—	20,0
Date	—	—	—	—
Friends: Older	21,4	14,3	13,0	20,0
Same age/younger	72,9	78,6	87,0	60,0
Relatives	—	7,1	—	—
Others	5,7	—	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	70	14	54	10
Place where smokers mostly smoke:				
At school	11,4	9,5	20,7	10,0
At work	3,8	—	3,5	—
At home/place where I live:				
when parents/guardians are in/out	12,7	33,3	36,2	20,0
when parents/guardians are out	35,4	33,3	24,1	40,0
At home of relatives	3,8	—	—	—
At home of friends	22,8	19,1	12,1	20,0
Another place	10,1	4,8	3,5	10,0
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	79	21	58	10
Time of day smokers have their first smoke of the day:				
First thing in the morning	58,3	54,6	77,1	44,4
Lunch-time/between 12 and 2 pm	16,7	27,3	14,8	22,2
After lunch but before evening meal	11,9	9,1	4,9	—
With/after the evening meal	7,1	9,1	3,3	22,2
Bed-time	6,0	—	—	11,1
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	84	22	61	9

Table 25 Context within which alcohol and other drugs are used by 10-21 years olds: Black communities in the RSA (1994) — current users (continued)

Context	**Urban (%)**		**Rural (%)**	
	Male	Female	Male	Female
Substances other than alcohol/cigarettes/ tobacco				
Usually use substances in company/in company and alone	50,1	47,6	47,6	40,4
Alone	49,9	52,4	52,4	59,6
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	379	479	250	270
Persons with whom users mostly use the substances concerned:				
Spouse/sexual partner	—	1,8	—	0,9
Date	—	0,4	—	—
Male friends: Older	5,8	1,3	5,9	—
Same age/younger	9,0	2,6	16,0	1,8
Female fiends: Older	—	1,3	0,8	1,8
Same age/younger	2,1	5,7	0,8	10,1
Relatives	31,1	40,8	48,7	51,4
Others/can't recall	52,1	46,1	27,7	34,0
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	190	228	119	109
Place where users mostly use substances concerned:				
Can't tell/remember	34,5	29,9	23,4	22,6
At home/place where I live	56,8	65,2	64,9	71,2
At friends' home	1,1	0,5	2,9	1,4
At school	1,8	1,1	5,3	3,3
At school/and at home	1,4	1,9	0,6	—
In the street	1,1	—	—	0,5
At a club/tavern/shebeen	1,4	0,5	1,8	0,5
Everywhere	1,7	0,3	0,6	0,5
Any secluded place, away from parents	0,4	0,5	0,6	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	287	368	171	212

Table 26: Context within which alcohol and other substances are used by blacks in the RSA and the self-governing states (14 years and older) — current users (1990)

Context	RSA %					
	Metros		Towns		Squatters	
	Male	Female	Male	Female	Male	Female
Amount spent on alcohol monthly						
R20 and less	13,2	32,7	18,5	53,2	16,3	22,0
R21-R59	31,8	28,6	43,5	31,9	31,0	40,2
R60 and above	55,0	38,8	38,0	14,9	52,7	37,8
TOTAL (%)	100,0	100,0	100,0	100,0	100,0	100,0
TOTAL (N)	129	98	92	47	129	82
Amount spent on substances other than alcohol monthly						
R20 and less	61,8	72,6	66,7	86,0	55,2	68,1
R21-R59	20,9	21,1	26,0	12,9	27,3	25,3
R60 and above	17,3	6,4	7,3	1,2	17,6	6,6
TOTAL (%)	100,0	100,0	100,0	100,0	100,0	100,0
TOTAL (N)	191	226	150	171	165	241
Persons with whom drinkers drink						
Spouse/partners	22,9	24,4	21,2	28,4	23,8	32,1
Friends	90,8	82,9	96,4	80,2	95,1	76,4
Relatives	79,6	56,1	71,7	65,4	74,1	74,3
Acquaintances	44,4	34,8	32,7	28,4	33,6	29,3
Strangers	22,9	23,2	29,2	30,9	23,8	25,7
TOTAL (N)[*]	153	164	113	81	143	140
Persons with whom users of substances other than alcohol use these						
Spouse/partner	38,7	41,8	39,1	31,3	41,2	47,6
Friends	67,0	58,8	85,9	56,6	76,5	65,0
Relatives	70,8	76,5	73,4	78,3	66,7	75,5
Acquaintances	30,2	26,5	20,3	16,9	21,6	21,7
Strangers	18,9	15,9	17,2	22,9	14,7	15,4
TOTAL (N)[*]	106	170	64	83	102	143

---

[*] Percentages do not add up to 100,0, as respondents were required to respond to each category instead of choosing between categories.

Table 26: Context within which alcohol and other substances are used by blacks in the RSA and the self-governing states (14 years and older) — current users (1990) (continued)

Context	**RSA %**					
	Metros		**Towns**		**Squatters**	
	Male	Female	Male	Female	Male	Female
Place where alcohol is used						
School	1,2	1,1	3,9	1,1	1,9	—
Work	11,5	1,1	9,4	6,8	7,1	2,6
Home	82,5	70,1	87,5	77,3	79,4	84,9
Home of relatives	61,8	41,2	63,3	51,1	61,3	58,6
Home of friends	67,3	47,5	71,1	52,3	69,0	46,7
Shebeen: Licensed	37,0	3,4	41,4	4,5	34,8	16,4
Not licensed	23,6	4,5	14,8	3,4	36,1	13,8
Do not know if licensed	29,1	6,8	27,3	14,8	34,8	12,5
Bar	25,5	4,0	31,3	9,1	19,4	8,6
Bottle-stores	21,2	4,0	27,3	4,5	11,6	6,6
Club/discotheque	26,1	11,3	16,4	1,1	16,8	11,2
Restaurant	9,1	4,0	16,4	1,1	5,8	3,9
Municipal/compound hall	8,5	—	6,3	—	7,1	3,3
Hotel lounge	18,2	10,7	26,6	6,8	9,0	3,3
Other place	—	—	—	—	—	—
TOTAL (N)*	165	177	128	88	155	152
Place where substances other than alcohol are used						
School	9,8	10,1	11,6	12,4	98,4	5,4
Work	30,8	22,0	42,1	23,7	30,0	17,7
Home	91,1	91,2	94,5	97,9	86,1	95,9
Home of relatives	42,5	40,2	47,6	49,5	42,2	45,2
Home of friends	42,1	31,8	44,5	37,6	45,6	34,2
Home of acquaintances	9,8	12,5	9,8	13,4	8,0	10,0
Club/discothéque	9,3	1,0	6,1	2,7	8,0	1,5
Hotel	7,0	1,7	7,3	3,8	3,3	0,8
Other place	0,9	0,3	1,2	0,5	2,2	—
TOTAL (N)*	214	296	164	186	180	260
Time of day drinkers usually take their first drink						
When waking up in the morning	8,4	4,0	7,8	8,2	9,9	8,1
Before 12 noon	18,7	15,8	18,8	17,6	23,0	18,8
Lunch-time	13,9	11,9	10,2	21,2	15,1	15,4
After lunch, before evening meal	48,8	48,0	40,2	44,7	30,5	45,6
With or after evening meal	7,8	14,1	11,7	4,7	10,5	10,2
Just before bed-time	2,4	6,2	2,3	3,5	2,0	2,0
TOTAL (%)	100,0	100,0	100,0	100,0	100,0	100,0
TOTAL (N)	166	177	128	85	152	149

Table 26: Context within which alcohol and other substances are used by blacks in the RSA and the self-governing states (14 years and older) — current users (1990) (continued)

Context	Self-governing states (%)	
	Male	Female
Amount spent on alcohol monthly		
R20 and less	42,5	74,4
R21-59	38,2	20,6
R60 and above	19,2	5,1
TOTAL (%)	100,0	100,0
TOTAL (N)	395	277
Amount spent on substances other than alcohol		
R20 and less	77,6	94,8
R21-R59	19,1	4,7
R60 and above	3,4	0,6
TOTAL (%)	100,0	100,0
TOTAL (N)	530	882
Persons with whom drinkers drink		
Friends	94,4	79,6
Relatives	65,3	64,8
Acquaintances	36,6	33,6
Strangers	26,9	24,3
TOTAL (N)*	368	286
Persons with whom users of substances other than alcohol use these		
Friends	87,5	70,7
Relatives	70,0	88,4
Acquaintances	47,5	46,2
Strangers	39,0	40,0
TOTAL (N)*	200	225
Place where alcohol is used		
School	1,4	1,0
Work	2,8	1,3
Home	78,5	74,3
Home of relatives	49,3	33,3
Home of friends	59,0	52,4
Shebeen: Licensed	14,6	4,0
Unlicenced	12,5	9,2
Do not know if licensed	31,8	19,6
Bar	20,3	6,4
Bottle-store	20,8	7,1
Club/discothéque	16,5	4,0
Restaurant	6,1	1,3
Municipal/compound hall	4,5	1,9
Hotel lounge	28,1	10,6
Other place	3,1	11,6
TOTAL (N)*	424	311

Table 26: Context within which alcohol and other substances are used by blacks in the RSA and the self-governing states (14 years and older) — current users (1990) (continued)

Context	**Self-governing states (%)**	
	Male	**Female**
Place where substances other than alcohol are used		
School	10,5	9,5
Work	34,6	18,2
Home	90,6	95,0
Home of relatives	39,1	32,2
Home of friends	38,7	24,4
Home of acquaintances	22,2	11,4
Club/discothéque	11,0	3,3
Hotel	11,2	2,5
Other place	4,1	1,6
TOTAL (N)*	563	971
Time of day drinkers usually take first drink		
Before 12 (noon)	19,1	23,5
Lunch-time	11,3	13,5
After lunch, before evening meal	52,8	42,4
With or after evening meal	13,0	14,8
Just before bed-time	3,8	5,8
TOTAL (%)	100,0	100,0
TOTAL (N)	424	311

Table 27: Experiences related to the use of alcohol, tobacco and other drugs by 10-21 years olds: Black communities in the RSA (1994) — current users

Experience	**Urban (%)**		**Rural (%)**	
	Male	Female	Male	Female
Can't remember/tell	86,5	79,0	79,2	91,2
Beaten by friends/parents	9,5	12,3	16,7	5,9
Vomiting/dizziness/sick	2,7	6,2	4,2	2,9
Punished at work	1,4	1,2	—	—
Car accident	—	1,2	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	74	81	24	34

Table 28: Drinking-related experiences of blacks in the RSA and the self-governing states (14 years and older) — current drinkers (1990)

Experiences	**RSA (%)**						**Self-governing states (%)**	
	Metros		**Towns**		**Squatters**			
	Male	Female	Male	Female	Male	Female	Male	Female
Involved in quarrels/ fights	22,6	8,4	33,8	16,8	32,0	15,8	18,9	12,2
Got sick	18,0	23,4	31,7	22,4	27,8	22,6	22,2	28,6
Unable to talk/walk	23,6	12,2	27,3	19,3	30,8	17,4	23,6	22,2
Problems at work	12,3	..	15,1	..	16,6	5,3	6,6	2,9
A drink first thing in the morning	24,6	6,5	27,3	11,2	21,9	13,7	18,6	10,6
Wanted to cut down	40,0	28,0	52,5	31,4	40.2	29,5	40,8	31,8
Advised to cut down	36,4	18,7	54,0	26,2	43,8	23,7	33,3	22,2
TOTAL (N)*	195	214	139	107	169	190	424	311

---

* Percentages do not add up to 100,0, as respondents were required to respond to each category instead of choosing between categories.

Table 29: Social pressure to use various substances as experienced by 10-21 year olds: Black communities in the RSA (1994)

Substance	Urban (%)						Rural (%)					
	Male*			Female**			Male***			Female•		
	Often	Sometimes	Never	Often	Sometimes	Never	Often	Sometimes	Never	Often	Sometimes	Never
Alcohol												
Do your friends/relatives ever try to persuade you to have a/another drink?	4,2	24,1	71,8	3,8	18,2	78,1	7,2	22,4	70,4	1,1	14,8	84,1
Have you ever been tempted to try a/another drink of alcohol when someone offered it?	3,4	17,4	79,2	2,9	11,5	85,6	8,0	17,6	74,4	1,9	9,6	88,5
Do you ever feel left out in company (e.g. at a party) because you are not drinking alcohol/not taking another drink?	4,8	11,1	84,2	2,1	9,8	88,1	9,6	13,2	77,2	4,1	8,9	87,0
Cigarettes/tobacco												
Do your friends/relatives ever try to persuade you to use/take another cigarette(s)/tobacco?	4,5	15,0	80,5	3,1	5,4	91,4	4,4	17,6	78,0	2,2	4,8	93,0
Do you ever feel left out in company because you are not using/not taking another cigarette(s)/tobacco	1,1	8,2	90,8	0,8	2,9	96,2	4,4	9,2	86,4	1,9	2,6	95,6
Dagga												
Do your friends/relatives ever try to persuade you to smoke dagga (again?)	3,7	6,3	90,0	2,1	1,3	96,7	2,0	8,4	89,7	0,7	1,9	97,4

---

* TOTAL (N): 379 ** TOTAL (N): 479 *** TOTAL; (N): 250 • TOTAL (N): 270

Table 29: Social pressure to use various substances as experienced by 10-21 year olds: Black communities in the RSA (1994) (continued)

Substance	Urban (%)						Rural (%)					
	Male*			**Female****			**Male*****			**Female***		
	Often	Sometimes	Never	Often	Sometimes	Never	Often	Sometime	Never	Often	Sometimes	Never
Do you ever feel left out in company (e.g. at a party) because you are not smoking dagga (again)?	1,1	3,7	95,3	0,4	1,0	98,5	3,2	1,6	95,2	0,4	0,4	99,3
White pipe (mixture of dagga and mandrax)												
Do your friends/relatives ever try to persuade you to use/take another white pipe?	1,6	1,3	97,1	0,6	0,6	98,8	0,4	1,2	98,4	0,4	0,4	99,3
Do you ever feel left out in company (e.g. at a party) because you are not using a/another white pipe?	0,3	1,1	98,7	0,2	0,4	99,4	0,8	0,4	98,8	0,4	—	99,6
Solvents												
Do your friends/relatives ever try to persuade you to sniff/take another sniff?	2,1	4,2	93,7	1,7	2,5	95,8	1,6	9,2	89,2	1,1	3,0	95,9
Do you ever feel left out if you do not sniff/do not take another sniff when you are with your friends/relatives?	—	1,3	98,7	0,4	0,8	98,7	1,2	4,0	94,8	1,9	0,4	97,8
Substances other than alcohol/cigarettes/dagga/white pipe/solvents												
Do your friends/relatives ever try to persuade you to use (another time) any of the relevant substances?	3,4	10,8	85,8	3,1	6,7	90,2	4,4	13,2	82,4	2,6	11,9	85,6
Do you ever feel left out in company (e.g. at a party) because you are not using (another time) the relevant substances?	2,1	4,8	93,1	2,7	2,1	95,2	4,4	13,2	82,4	2,6	11,9	85,6

Table 30: Demand for and access to drinking among blacks in the RSA and the self-governing states (14 years and older) (1990)

Demand/Access	RSA (%)						Self-governing states (%)	
	Metros		Towns		Squatters			
	Male	Female	Male	Female	Male	Female	Male	Female
Demand								
Persistent offers to have a drink	31,3	20,9	40,6	24,2	54,5	29,3	29,8	15,8
Refilling of drink before empty	20,2	10,5	24,4	10,5	31,3	15,3	19,3	8,4
Drinks bought in rounds	35,0	13,8	37,2	14,2	47,4	20,2	26,0	10,1
Offered no alternative to alcohol	16,9	11,3	20,6	9,6	22,8	10,8	15,3	11,5
Criticism/jokes when turning down a drink	29,2	19,8	35,0	18,7	41,2	22,0	33,8	23,1
Accessibility								
Obtaining alcohol in community:								
Difficult/most difficult	9,5	9,0	5,6	13,7	7,6	12,2	11,1	12,0
Easy/very easy	83,5	74,9	86,7	73,1	85,3	77,7	82,8	73,8
In community:								
Bottle-stores	72,4	73,2	86,7	81,7	51,2	39,7	92,0	87,5
Public bars	58,4	53,1	73,3	65,8	27,0	25,1	80,9	76,9
Hotels	29,6	18,1	42,8	32,4	11,4	12,5	65,7	48,3
Shebeens	89,3	85,6	93,3	93,2	86,7	85,7	89,5	87,7
Supermarkets stocking alcohol	34,6	29,9	30,0	24,2	12,8	11,9	17,1	15,5
Other	–	–	–	–	–	..	4,3	4,4
TOTAL (N)*	243	354	180	219	211	287	675	1 115

---

* Percentages do not add up to 100,0, as respondents were required to respond to each category instead of choosing between categories.

Table 31: Knowledge and acceptability of alcohol/drug-related services of 10-21 year olds: Black communities in the RSA (1994) — 'Yes' responses

Services	Urban (%)		Rural (%)	
	Male	**Female**	**Male**	**Female**
Phoenix House (Johannesburg)	34,0	33,4	20,0	28,5
Church/priest/minister	59,4	63,5	52,0	60,7
SANCA clinic	60,2	59,7	43,2	45,6
Sangoma	16,9	17,1	18,0	22,6
Social worker in community	71,5	71,0	60,0	63,3
Health clinic	74,1	73,5	60,8	65,6
Family/friends	54,4	58,9	50,8	53,3
Medical doctor	73,1	72,2	56,8	68,9
Others: (Anyone available, any local facility, jail, assist person personally, Alcoholics Anonymous, teachers, parents.)	3,7	4,6	2,8	3,0
TOTAL (N)*	379	479	250	270

---

* Percentages do not add up to 100,00, as respondents were required to respond to each category instead of choosing between categories.

Table 32: Responses to AIDS-related matters given by 10-21 year olds: Black communities in the RSA (1994)

AIDS-related matters	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
Knowledge of AIDS				
Yes	63,3	57,8	52,8	53,0
No	32,7	37,4	45,2	45,2
Uncertain	4,0	4,8	2,0	1,9
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	379	479	250	270
What is AIDS?				
Sexually transmitted disease	41,4	52,8	36,2	30,3
Killer/dangerous/incurable disease	44,7	35,4	52,3	50,7
Acquired Immune Deficiency Syndrome	0,4	0,4	—	1,4
Virus	7,6	7,8	7,7	14,1
Disease manifesting pimples/sores in face	1,7	1,1	1,5	1,4
Disease resulting from *funny* sex	0,4	—	—	—
Disease resulting from blood transfusions	1,3	—	1,5	0,7
Disease resulting from rape	0,4	0,4	—	—
Can't say much	2,1	2,2	0,8	1,4
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	237	271	130	142
Tested for AIDS				
Yes	4,2	3,6	0,8	2,2
No	95,3	96,5	99,2	97,8
Wasn't sure	0,5	—	—	—
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	379	479	250	270
Young people need more information on AIDS				
Yes	55,7	58,0	47,6	52,4
No	44,3	42,0	53,3	47,6
TOTAL (%)	100,0	100,0	100,0	100,0
TOTAL (N)	379	479	250	270

Table 32: Responses to AIDS-related matters given by 10-21 year olds: Black communities in the RSA (1994) (continued)

AIDS-related matters	**Urban (%)**		**Rural (%)**	
	Male	**Female**	**Male**	**Female**
AIDS-related information needed by young people				
How to prevent/avoid AIDS	33,2	27,3	44,5	37,5
Causes of AIDS	27,5	24,8	31,9	34,0
Symptoms of AIDS/how to diagnose	1,4	1,8	0,8	—
Whatever is needed as long as it is provided:				
Through nurses	8,5	8,3	0,8	2,8
At school as part of the syllabus	12,8	11,5	6,7	8,3
On a face-to-face basis at e.g. workshops	4,3	9,7	5,0	6,9
Through civics	—	—	0,8	0,7
Through literature	3,3	2,2	0,8	2,1
Whatever is needed as long as it is done through the TV/radio	7,6	10,4	4,2	4,9
Not sure	1,4	4,0	4,4	2,8
TOTAL (N)*	211	278	119	144

---

* Percentages do not add up to 100,00, as each respondent could mention a specific type of information instead of choosing between various pre-defined types of information.

Are our disadvantaged young people at risk with regard to alcohol, tobacco, and other drug related problems? This research identifies various areas of risk - particularly their implications for HIV/AIDS infection. It establishes some baseline for monitoring drug intake among South African youth and suggests ideas to facilitate the development of national, comprehensive and research-based drug-related preventive programmes. The national survey findings are supported by in-depth and other fairly open-ended explorations of the nature of drug-related behaviour among a group of black children in Soweto near Johannesburg. The current levels of knowledge and willingness to use preventive services are also explored. The authors offer preventive guidelines and recommendations in the interest of securing a better future for all in South Africa.

Sylvain de Miranda is a medical doctor with vast experience in the field of substance abuse and its treatment. He is the founding medical officer of Phoenix House in Johannesburg and is currently the director of clinical services for SANCA in that city. Sylvain serves on the Drug Advisory Board and is a member of, *inter alia*, the SA Medicines Control Council and the Ministerial Committee on Mental Health and Substance Abuse. He is a visiting lecturer at most SA universities and has delivered numerous international papers on the subject of alcohol, tobacco and other drug abuse.

Lee Rocha-Silva is a researcher at the HSRC. She specialises in alcohol, tobacco and other drug-related research. Lee has published extensively in various scientific journals and has authored numerous papers and reports.

HSRC
RGN
Publishers | Uitgewers

ISBN 0-7969-1704-3
9 780796 917041

BEST COPY AVAILABLE